Attachment J: Detailed Contract Deliverables
(Use in conjunction with Appendix #26 – Deliverables and Report Matrix)

Attachment J:

Detailed Contract Deliverables

Amended 6/30/2022

TABLE OF CONTENTS

1. **Background & Overview**

This summary of deliverables incorporates, by reference, the originating eRFP Number DBH0000433. This contract is the result of Sole Source (SN-SoleSource-44100-142) posted 1/18/2022, to continue engagement with Beacon Health Options. This document: Attachment J, Detailed Contract Deliverables has been updated to reflect the current state of the contract and DBHDD service system, as needed.

In the original RFP, cited above, there were some attachments that offered potential bidders context related to DBHDD service system, volume, etc. Where this context is no longer needed due to the current engagement of the vendor, these will be noted as removed but not replaced. This is because Beacon Health Options is fully engaged with DBHDD and has a detailed knowledge of the history and current state. The removal of these contextual sections and appendices does not reflect a change in deliverables.

In other areas, deliverables have been updated or removed to reflect changes in deliverables as noted in the attached Change Log.

1.1 **Current BH Services Delivery System Overview**
Removed as the current ASO contractor Beacon Health Options is fully engaged with DBHDD and has a working knowledge of the BH service delivery system.

1.2 **Current IDD Services and Supports System Overview**
Removed as the current ASO contractor Beacon Health Options is fully engaged with DBHDD and has a working knowledge of the IDD service delivery system.

1.3 **Current IDD Services and Supports System Overview**

1.4 **Covered Populations**
DBHDD serves eligible individuals in need of treatment or supports for concerns related to a MI, SUD, and/or IDD. Specifically, these populations include:

1.4.1 Medicaid Eligible Populations

1.4.1.1 Individuals enrolled in the DCH's Georgia Families Program: The Georgia families managed care Medicaid Program (which includes PeachCare for Kids and LIM covered lives) is operated by the DCH. Contracted CMOs manage health care services for enrollees, including BH, under a capitated arrangement with DCH. Individuals who are eligible for these capitated programs are only included under this Contract for the brief period between Medicaid acceptance and enrollment with the CMO (approximately sixty (60) days).

1.4.1.2 Individuals who have been determined "Medicaid Aged, Blind, and Disabled": The DCH has delegated its authority to administer BH Medicaid FFS benefits under Medicaid Rehabilitation Option to the DBHDD. The State's DHS DFCS supports, and will continue to support, general Medicaid financial and eligibility processes. These Medicaid Beneficiaries' BH FFS benefits are administered under this Contract. Other Medicaid-funded services such as inpatient hospital

or other outpatient services are not administered within the scope of this contract.

1.4.1.3 Individuals enrolled in DBHDD/DCH Medicaid Waivers: The DCH conducts, and will continue to conduct, financial eligibility determinations for Waiver services through an interagency agreement with DFCS. The DCH has delegated its authority to operate two (2) Medicaid HCBS to the DBHDD which include the following:

1.4.1.3.1 COMP

1.4.1.3.2 NOW

1.4.1.3.3 COMP and NOW Waivers: DBHDD Regional Field Offices determine functional pre- eligibility, and will continue to determine functional pre- eligibility, for the COMP and NOW Waiver Programs in accordance with Waiver policies. Eligibility criteria are delineated in Part I, Section II of the DBHDD Provider Manual for Community Developmental Disabilities Providers in Appendix 1 and the COMP and NOW Waivers in Appendices 2 and 3. Information systems, processes, and monitoring to aid in the DBHDD's administration of the services and supports of Individuals in the COMP and NOW Waivers are responsibilities of the Contractor as delineated under this Contract.

1.4.1.4 IDD Individuals who are Medicaid enrolled, but are not yet Waiver enrolled. These Individuals may require DBHDD-funded services as defined in Section I, Part I of the DBHDD Provider Manual for Community DD Providers in Appendix 1.

1.4.1.5 Medicaid recipients with suspected or confirmed diagnoses of mental illness, intellectual disability (ID) and/or a related condition (RC) who need a Level II evaluation through the Preadmission Screening and Resident Review (PASRR) program (See Appendix 28). The Level II PASRR evaluations are included in the scope of work under this Contract.

1.4.2 Non-Medicaid Eligible Populations

1.4.2.1 DBHDD-funded, non-Medicaid enrolled BH populations are individuals who meet the age, diagnostic, functional, biopsychosocial, risk, and financial criteria of a Core Customer as described in Section I, Part I of the DBHDD Provider Manual for Community BH Providers in Appendix 6. Priority populations are also identified in this appendix.

1.4.2.2 DBHDD State-funded IDD populations included in this Contract are Individuals who meet the age, diagnostic, functional, and financial criteria as described in Section I, Part I of the DBHDD Provider Manual for Community DD Providers in Appendix 1.

1.4.2.3 IDD populations may be eligible for DBHDD-funded Family Support Services as described in the DBHDD Policy for Family Supports for DD Services, 02-401 (see Appendix 7).

1.4.3 Other Populations

Individuals who qualify for services funded by state funds or federal grants. State funds may be used to pay for needed services that are not covered by Medicaid or another third-party insurer. In some cases, federal grants allow the support of an Individual who may be Medicaid-eligible, but not Medicaid-enrolled; or allow coverage of a Medicaid Recipient for a service that is not covered by Medicaid or another insurer. Those populations included under this Contract are Individuals who meet criteria for:

1.4.3.1 State funds.

1.4.3.2 The Mental Health Block Grant.

1.4.3.3 The Substance Abuse, Prevention, and Treatment Block Grant.

1.4.3.4 Projects for Assistance in Transition from Homelessness (PATH) Program

1.4.3.5 Title XX Social Services Block Grant.

1.4.3.6 Ready For Work.

1.4.4 All individuals in Georgia are eligible for GCAL services as delineated in Section 6. GCAL.

1.4.5 Non-covered Populations: Effective March 3, 2014, these covered lives will be managed through a new DCH managed care initiative for foster care, adoption assistance (previously served by the Georgia Families Program), and some selected juvenile justice-involved youth (previously served by the Georgia Families Program). This new DCH-administered program is titled Georgia Families 360°.

1.5 **Overview of Administrative Services Organization (ASO) Functions and Responsibilities**

Removed as the current ASO contractor Beacon Health Options is fully engaged with DBHDD and has a working knowledge of DBHDD's expectation of their functions and responsibilities.

2. **General Requirements Contact Extension Amended beginning Fiscal Year 2023**

2.1 The Contractor will successfully administer the requirements of this Contract based on a complete understanding of the Georgia DBHDD and DCH, BH, and IDD services and supports delivery system, including how requirements vary as a result of:

2.1.1 Beneficiary needs.

2.1.2 Population eligibility.

2.1.3 Covered benefits or services.

2.1.4 Funding source.

2.1.5 Beneficiary location.

2.2 The Contractor will administer the requirements of this Contract with the intent of achieving the following DBHDD goals:

2.2.1 Coordinate and facilitate access to high-quality BH and IDD services and supports, informed by evidence-based practice (EBP), practice guidelines, or best practices, in a cost-effective manner

2.2.2 Coordinate and facilitate access to culturally and linguistically appropriate services and supports that maximize personal and family voice and choice.

2.2.3 Deliver clinically appropriate telephonic crisis intervention, triage, mobile crisis dispatch, warm transfer, and referral services to persons in Georgia seeking assistance for a behavioral problem related to a BH and/or IDD diagnosis, condition, crisis, or emergency

2.2.4 Through record reviews, training, and technical assistance activities, assist Providers in adhering to practice guidelines to ensure each individual obtains a comprehensive assessment and POC consistent with his or her assessed needs

2.2.5 Through record reviews, training, and technical assistance activities, assist Providers in adhering to practice guidelines to ensure each individual with an IDD obtains a comprehensive evaluation and ISP consistent with his or her assessed needs.

2.2.6 Conduct state-of-the art UM/UR, QM, data management, and reporting that:

2.2.6.1 Improves Provider performance through streamlined Provider audits, Provider Performance Profiles, and outcomes data collection and management.

2.2.6.2 Supports Providers in the integration of individuals into their communities utilizing community supports and resources, consistent with personal needs, and the individual's needs, preferences, choices, and informed consent.

2.2.6.3 Promotes rapid access to qualified Providers, peer supports, and other community-based resources that offer effective services and supports (i.e., "no wrong door").

2.2.6.4 Promotes recovery, resilience, community integration, and wellness for individuals with BH conditions.

2.2.6.5 Promotes person-centered services and supports that enhance independence and community inclusion for individuals with IDD.

2.2.6.6 Focuses on the whole health of individuals with BH conditions and/or IDD.

2.2.6.7 Employs meaningful involvement of individuals, family members, peer-run organizations, Providers, advocacy organizations, and other stakeholders in decision-making and oversight as appropriate.

2.2.6.8 Utilizes State resources in a cost-effective manner that improves treatment, service and support outcomes, and the overall quality of life for individuals.

3. **Administrative Requirements**

3.1 Organizational Requirements

3.1.1 The Contractor is responsible for the effective performance of all Contract requirements, regardless of who performs them, and will submit, as part of its response, information about its subcontracts in sufficient detail to verify the expertise of the subcontractor and demonstrate how the subcontracted function(s) will operate and be managed by the Contractor.

3.1.2 The Contract must maintain appropriate accreditation as approved by DBHDD. Current accreditations are:

3.1.2.1 Beacon Health Options:
- 3.1.2.1.1 NCQA
- 3.1.2.1.2 American Association of Suicidology

3.1.2.2 Qlarant:
- 3.1.2.2.1 ISO 9001
- 3.1.2.2.2 Capability Maturity Model Integration

3.1.2.3 BHL (for GCAL):
- 3.1.2.3.1 American Association of Suicidology
- 3.1.2.3.2 CARF
- 3.1.2.3.3 International Council for Helplines
- 3.1.2.3.4 NADD

3.1.3 The Contractor will be fully accountable and responsible for the actions of any subsidiary organization, affiliate, or subcontractor associated with this Contract.

3.1.4 The Contractor will grant the State and/or the federal government the right to examine any directly pertinent books, documents, papers, and records of the Contractor, subsidiary organization, subcontractor, or affiliate that will perform functions or have responsibilities related to this Contract.

3.1.5 The Offeror confirms it has no interest, direct or indirect, which would conflict with the performance of this Contract and will not employ or subcontract with any Entity or person having such a conflict.

3.1.6 The Offeror (to include any subcontractors) may not knowingly have a relationship with the following:

3.1.6.1 An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

3.1.6.2 An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a) (1).

3.1.6.3 A relationship is described as follows:

3.1.6.3.1 A director, officer, or partner.

3.1.6.3.2 A person with beneficial ownership of 5% or more.

3.1.6.3.3 A person with an employment, consulting, or other arrangement with the Entity.

3.1.7 Contracts will not be made with parties listed on the non-procurements portion of the General Services Administration's "Lists of Parties Excluded for Federal Procurement or Non-Procurement Program." This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority. Contractors with awards that exceed the simplified acquisition threshold (currently one-hundred thousand dollars ($100,000)) will provide the required certification regarding their exclusion status and that of their principals prior to award.

3.1.8 The Contractor will be the primary contact for DBHDD; DBHDD only interacts with any of the Contractor's subsidiary organizations, affiliates, or subcontractors, when DBHDD initiates such contact or there are situations for which DBHDD and the Contractor approve direct contact or contract deliverables that require the subsidiary organizations, affiliates, or subcontractors to have contact with DBHDD.

3.2 Facilities and Staffing Requirements

3.2.1 The Contractor will have the facilities, financial resources, and an organizational structure sufficient to support the effective operations of this Contract.

3.2.2 The Contractor will have sufficient staff to facilitate regional involvement and communication with individuals, families/caretakers, Recipients, Providers, DBHDD and other stakeholders. Contractor's staff members will work with DBHDD staff in the implementation of regional QM activities, the coordination of required training and other activities as needed.

3.2.3 The Successful Offeror will administer the Contract through a local office (i.e., in Atlanta metro area). Some of the Contractor's staff will attend frequent meetings with DBHDD management staff at the DBHDD main offices located in downtown Atlanta, Georgia. Preference will be given to administrative office locations in close proximity to DBHDD's State Office.

3.2.4 The local office will manage, at a minimum, the following functions:

3.2.4.1 Executive team responsibilities.

3.2.4.2 GCAL services.

3.2.4.3 UM/UR (except for second level specialty review, second level physician review, or Appeals).
3.2.4.4 QM activities, including oversight of onsite reviews.
3.2.4.5 Network management.
3.2.4.6 Complaint resolution.
3.2.4.7 Hiring, orientation, and training activities.
3.2.4.8 Ad hoc data analysis and reporting.
3.2.4.9 Information System (IS) maintenance and development.

3.2.5 The following full-time management team Employees and staff in key positions listed in 3.2.6 will be based at the local office referenced in 3.2.3.

Management team positions include:

3.2.5.1 The Georgia Chief Executive Officer (CEO) is dedicated solely to the functions herein and has ultimate responsibility for Contract performance. This position will serve as the full-time Contract manager and primary contact for the Department. The CEO will have a minimum of at least ten (10) years of management experience, preferably in human services.
3.2.5.2 The Chief Medical Officer/Medical Director (MD) will have an unencumbered Georgia license to practice medicine, and have responsibility for the effective operation of GCAL, UM/UR and QM programs.
3.2.5.3 The Behavioral Health Administrative Director will have a license to independently practice as a BH professional in the State and have at least seven (7) years of experience in BH service delivery management for adults with SPMI and SUD. The BH Director will be responsible for the day-to-day clinical operations, policies, and procedures as they relate to BH concerns.
3.2.5.4 The Developmental Disabilities Administrative Director will have at least seven (7) years' experience in the administration of programs and services for persons with IDD in areas such as supported living, support coordination, supported employment, or day or residential services. The candidate will also have at least three (3) years' experience directing QM activities for individuals with IDD.

3.2.6 Initially, and throughout the term of the Contract, DBHDD will review credentials and experience of potential management team (above) and key position (below) candidates and provide approval prior to hire or position assignment.

Key positions include:

3.2.6.1 A full-time Director of Management IS, with a minimum of five (5) years' experience in data management for health care.
3.2.6.2 A full-time QM Director, with at least five (5) years recent evidence-based QM model experience in BH or IDD, who is preferably a licensed clinician.
3.2.6.3 A Director of Independence and Recovery Advocacy with lived experience as an individual who has received BH or IDD services or is

a family member of an individual who has received BH or IDD service through similar public programs. This individual will report directly to a member of the Contractor's management team and will provide advocacy and representation of the lived experience voice in shaping the Contractor's practices, policies, and outcomes.

3.2.6.4 A full-time Director for Data Management and Reporting, with at least five (5) years' experience in the collection, analysis, and reporting of BH or IDD data and trends, preferably in the public sector.

3.2.6.5 A full-time GCAL Director, who at a minimum, will have completed a master's and/or nursing degree, will possess an independent license to practice as a physician, psychologist, registered nurse, social worker, professional counselor, or marriage and family therapist in the State, and will have three (3) years' post-graduate experience in a leadership role managing a BH crisis line.

3.2.6.6 A full-time Director of Utilization Management and Review who holds a Georgia license as an APRN (psychiatry specialty), LCSW, LPC, or LMFT with a minimum of three (3) years supervisory experience in utilization management for behavioral health services or five (5) years' experience in utilization management for behavioral health services.

3.2.7 The Contractor maintains the following staff-level positions:

3.2.7.1 Customer Services r responsible for coordinating and overseeing response to claims inquires and problems

3.2.7.2 Identified designated personnel to responding to Contractor-related issues and concerns.

3.2.7.3 Crisis Intervention Specialists responsible for providing telephonic crisis intervention, triage, and follow-up. Crisis Intervention Specialists will include Crisis Counselors in four tiers:

- Tier I: Certified Peer Specialists or Bachelor's degree;
- Tier II: Master's degree;
- Tier III: Associate license;
- Tier IV: Unrestricted/independent license.

At all times, at least one crisis intervention specialist with experience conducting behavioral crisis intervention for individuals with IDD will be available as defined in Section 6. GCAL.

3.2.7.4 Utilization Managers/Care Coordinators responsible for conducting UM/UR activities including, but not limited to: registration, eligibility verification, authorizations, Prior Authorizations, facilitating care coordination, discharge planning, community transitions, and Provider access. The Contractor will utilize clinicians licensed for independent practice within the State, with a minimum of five (5) years' direct service experience in the delivery of public BH services and at least one (1) year experience conducting utilization review.

3.2.7.5 Physician Advisors responsible for conducting UM/UR functions including, but not limited to: denials and other Adverse Actions, Peer Review, and appeals for intensive BH services. The Contractor will utilize physicians, psychiatrists, and psychologists, with an unencumbered license to independently practice in the state in which

they are located, with at least three (3) years' direct service experience in public BH services and experience or a demonstrated competency with performing UM.

3.2.7.6 Network Management Staff responsible for pre-qualification and verification of Provider qualifications and credentials (if applicable), assessment of network adequacy, and maintaining the online Provider Network directory. The Contractor will require that the manager responsible for supervising these staff have at least three (3) years' experience with provider enrollment and network management.

3.2.7.7 QM Staff responsible for designing and implementing the Contractor's QM program and plan while supporting DBHDD's QM program and plan; producing Provider performance profiles; conducting BH audits, QEPRs, and QUTAC in coordination with DBHDD; conducting reporting, complaint investigations, and supporting the State in Provider-related Adverse Action/Fair Hearings; auditing Contractor documentation and records, and monitoring Contractor compliance. QM staff will comprise:

3.2.7.7.1 Teams conducting QEPRs, and QUTAC must include at least one qualified IDD professional (also known as a Developmental Disabilities Professional-DDP) as defined the DBHDD Provider Manual for Community DD Providers (see Appendix 1) (a) with at least three (3) years' experience in the administration of services for individuals with IDD. Preferably, the staff will also have at least three (3) years' experience with QM activities for individuals with IDD.

3.2.7.7.2 Teams conducting BH audits will include at least one clinician licensed for independent practice within the State of Georgia with a minimum of three (3) years' experience in the delivery and/or clinical audits of public BH services and three (3) years' experience in supervision, managed care, or other BH oversight functions.

3.2.7.7.3 IDD staff who review and address the results of the and QEPRs, attend quarterly regional quality improvement council meetings, possess knowledge of best practices in the delivery of services to individuals with IDD, conduct training related to best practices and practice guidelines, have experience in IDD QM, and be readily available to the Department via phone, email, and web during business hours.

3.2.7.8 General Customer Service Representatives responsible for initial call response or routing for calls related to inquiries, complaints, and other customer service functions related to the Contractor's functions.

3.2.7.9 Claims Customer Service Representatives responsible for facilitating authorization and claims inquiries from Providers and other claims customer service functions.

3.2.7.10 Information Technology staff responsible for system and database design, development, modifications, enhancements, maintenance, and interfaces; maintaining an accessible and user-friendly website and associated processes; modifying data fields, websites, systems and reports as requested by DBHDD; and assuring system and data accessibility with appropriate security and privacy measures, and other information technology functions. All enhancements crossing over contracts will be completed under the original enhancement agreement.

3.2.7.11 Data Management and Reporting staff responsible for designing and producing accurate, timely and meaningful routine and ad hoc reports; maintaining and analyzing information gathered during QEPRs, and QUTACS, Medicaid claims reviews, Provider audits, and other UM and QM processes.

3.2.7.12 Financial Management Staff responsible for supporting adherence to accounting and finance-related policies, reporting, compliance, and other financial functions, including, projection of DBHDD financial expenditures based on service utilization information and trend analysis.

3.2.7.13 Compliance Staff responsible for ensuring adherence to the compliance plan, investigating incidents, and implementing policy and procedure relating to suspected Fraud and Abuse.

3.2.8 Additional staffing requirements and qualifications are delineated in associated sections.

3.2.9 Contractor will develop and implement policies and procedures for on-boarding and off- boarding of staff.

3.2.10 The Contractor will provide quarterly staffing reports to DBHDD. Reports will include, but are not limited to:

3.2.10.1 List of current staff, position, hire date.

3.2.10.2 List of vacancies by position type, length of time position has been open, and reason(s) for vacancies.

3.2.10.3 Recruiting and hiring actions, including anticipated hires and hire dates by position, upon request.

3.2.10.4 Performance relative to applicable performance measures (PMs) and performance guarantees (PGs) outlined in Appendices 18 and 42.

3.2.11 Hiring PGs and PMs include the following and are further defined in Appendix 42

3.2.11.1 Existing management team positions will remain open no longer than sixteen (16) weeks, with assignment of an “Acting” team member to fill the position during the time the position is open.

3.2.11.2 Existing key positions, professionals, and manager positions will remain open no longer than fourteen (14) weeks, with assignment of an “Acting” key position individual during the time the position is open.

3.2.11.3 Existing staff level positions will remain open no longer than ten (10) weeks.

3.2.11.4 All new hires will meet the requirements of the position and the Contractor will obtain DBHDD pre-approval when required by this Contract.

3.3 Compliance

3.3.1 General Requirements

The Contractor will:

3.3.1.1 Comply with all applicable federal laws and regulations including, but not limited to: Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; Equal Employment Opportunity Provisions; the Rehabilitation Act of 1973; HIPAA, HITECH, and the ADA.

3.3.1.2 Comply with all federal or State laws, rules, and regulations to include but not limited to state confidentiality laws.

3.3.1.3 Comply with all requirements and standards including, but not limited to: Contract requirements, performance standards, and all documents incorporated by reference, including DBHDD procedure manuals and guidelines.

3.3.1.4 Implement established policies and procedures to conduct internal compliance monitoring and auditing.

3.3.1.5 Implement established policies and procedures to detect, investigate, and promptly address suspected Fraud and Abuse consistent with federal, State, and DBHDD requirements.

3.3.2 All information, whether data, documents, or reports that contain information arising out of this Contract, is owned by DBHDD. The Offeror is prohibited from sharing or publishing DBHDD information or reports without the prior written consent of the DBHDD's Contract manager.

3.3.3 Fraud and Abuse

For programs for which the Contractor pays claims, the Contractor will:

3.3.1.1. In order to reduce the incidence of Fraud and Abuse, establish policies and procedures governing program integrity, which comply with all State and federal program integrity requirements.

3.3.1.2. Develop and maintain a written Fraud and Abuse Prevention Plan with internal controls designed to prevent, reduce, detect, correct, and report known or suspected Fraud and Abuse activities.

3.3.1.3. Working with DBHDD ensure Provider Performance Profiles, prequalification and credentials verification processes identify and address claims and encounter practices for Providers who:

3.3.1.3.1. Submit falsified claims or encounter data or service reports;

3.3.1.3.2. Submit overstated reports or up-coded levels of service;

3.3.1.3.3. Alter, falsify, or destroy clinical record documentation;

3.3.1.3.4. Make false statements relating to credentials;

3.3.1.3.5. Misrepresent information to justify referrals;

3.3.1.3.6. Fail to render medically necessary covered services they are obligated to provide according to their Contracts;

3.3.1.3.7. Over-charge individuals for covered services.

3.3.1.4. Under the State's Surveillance Utilization Review Program, DCH is responsible for Fraud and Abuse reviews for its FFS claims. However, DBHDD and the Contractor must review records and POC and ISP provision to ensure services rendered are appropriate and consistent with the approved POC and ISP.

3.3.1.5. Consistent with 42 CFR 456 Utilization Control the Contractor will work with DBHDD and DCH to submit a detailed description of the Medicaid UM/UR process that includes the following information to satisfy the filing requirement:

3.3.1.5.1. The Contractor will ensure Providers do not claim for HCBS services while an individual is in an institution or hospital.

3.3.1.5.2. Established UM/UR criteria used for the investigation of acts of suspected insurance fraud relating to the types of insurance offered.

3.3.1.5.3. The Contractor's UM/UR department will report all suspected fraudulent acts directly to DBHDD, Medicaid and Medicaid Fraud Control Units (MFCUs), and private insurers (as applicable).

3.3.1.5.4. All reports of suspected fraud contain information that clearly defines and supports the allegation of suspicious activity.

3.3.1.5.5. The Contractor will record the date that suspected fraudulent activity was detected and the date that reports of such suspected fraud were sent to DBHDD Medicaid and Medicaid Fraud Control Units.

3.3.1.5.6. The Contractor will provide ongoing training relating to the detection and investigation of fraudulent acts for all UM/UR personnel involved in anti-fraud related efforts.

3.3.1.5.7. The Contractor will ensure that individuals and families know how to report potentially fraudulent activities.

3.3.1.5.8. The Contractor will document and make available contact information including names, email addresses, and telephone numbers, for personnel designated by the UM/UR unit as responsible for achieving and maintaining compliance with this Contract requirement.

3.3.1.5.9. The Contractor will make available to all authorized federal and State oversight agencies and their agents including, but not limited to: the DBHDD, Medicaid and MFCUs, any and all administrative, financial, and medical records and data relating to the delivery of items or services for which Medicaid monies are expended.

3.3.1.5.10. The Contractor will allow access to all authorized federal and State oversight agencies and their agents including, but not limited to: DBHDD, Medicaid DCH, and MFCUs to any place of business and all medical records and data, as required by State and/or federal law. Access will be during normal business hours, except under special circumstances when the DBHDD, Medicaid, DCH, or MFCU will have after-hours admission. The DBHDD,

Medicaid, DCH, and MFCU determine the need for special circumstances.

3.3.1.6. The Contractor's Fraud and Abuse policies and procedures will ensure, at a minimum, that:

3.3.1.6.1. The Contractor cooperates fully in and supports any investigation by federal and State oversight agencies and any subsequent legal action that may result from such an investigation.

3.3.1.6.2. The Contractor does not retaliate against any individual who reports violations of the Contractor's Fraud and Abuse policies and procedures or suspected Fraud and Abuse.

3.3.1.6.3. The Contractor does not knowingly have affiliations with individuals debarred or excluded by federal agencies.

3.3.1.6.4. The Contractor uses the federal List of Excluded Individuals/Entities, or its equivalent, to identify excluded parties during the process of engaging the services of new Employees, Entities, Providers, and during renewal of agreements and re-credentialing.

3.3.1.6.5. The Contractor will not engage the services of an Entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act.

3.3.1.6.6. The Contractor will make available written Fraud and Abuse policies to all Employees. If the Contractor has an employee handbook, the Contractor includes specific information about the Contractor's policies, and the rights of Employees to be protected as whistleblowers.

3.3.1.6.7. The Contractor will provide details, post on its public website, and will periodically educate Employees, individuals/families served, Entities and Providers about the following, as required by § 6032 of the federal Deficit Reduction Act of 2005:

3.3.1.6.7.1. The False Claim Act.

3.3.1.6.7.2. The penalties for submitting false claims and statements.

3.3.1.6.7.3. Whistleblower protections.

3.3.1.6.7.4. The law's role in preventing and detecting Fraud, Waste and Abuse.

3.3.1.6.7.5. Each person's responsibility relating to detection and prevention.

3.3.1.6.7.6. The toll-free state telephone numbers for reporting Fraud and Abuse.

3.3.1.6.8. The Contractor will query potential non-provider subcontractors/Entities (e.g., accountants, attorneys), before contracting to determine whether the subcontractor/Entity has any existing or pending contract(s) with the State. If any are found, the

Contractor will notify DBHDD, Medicaid, and MFCU.

3.3.1.6.9. The Contractor will meet with the DBHDD, Medicaid, and MFCU periodically, at the agency's request, to discuss Fraud, Abuse, neglect, and overpayment issues.

3.3.1.6.10. Nothing in this Contract requires that the Contractor assures that non-participating providers are compliant with this Contract or State and/or federal law, but the Contractor is responsible for reporting suspected Fraud and Abuse by non-participating providers when detected.

3.3.1.6.11. The Contractor will:

3.3.1.6.11.1. Designate a Corporate Compliance Officer to collaborate with the State regarding Fraud, Waste, and Abuse program requirements.

3.3.1.6.11.1.1. The Compliance Officer will have unrestricted access to the Contractor's governing body for compliance reporting, including Fraud, Waste, and Abuse.

3.3.1.6.11.2. Hire adequate staff and allocate adequate resources to enable the Compliance Officer to investigate unusual incidents and develop and implement action plans relating to suspected Fraud and Abuse.

3.3.1.6.11.3. Develop and maintain a process to screen all Provider Medicaid encounters for potential Fraud, Waste, and Abuse.

3.3.1.6.11.4. Have information on their website that provides instructions on how to report suspected Fraud, Waste, and Abuse.

3.3.1.6.11.5. Report, in accordance with State and federal laws and regulations, any incident of suspected Fraud, Waste, and Abuse for which the Contractor has been made aware. Immediate notification to the State is required, with written notification to the State to follow within two (2) business days of discovery.

3.3.1.6.11.6. Develop and maintain sufficient internal controls to prevent and detect Fraud, Waste, and Abuse.

4. Eligibility and Enrollment

4.1 General Requirements

4.1.1 The Contractor will support the DBHDD in prudently managing its resources to ensure the support of individuals in need of BH and IDD services and supports.

4.1.2 The Contractor will support the system in making benefits available to individuals who meet the established functional, diagnostic, and financial eligibility criteria, consistent with DBHDD's identified priority populations.

4.1.3 The Contractor will make eligibility and enrollment determinations that reserve State-funding as a last payment option (or a complementary payment option) as federal and State law permits.

4.1.4 The Contractor will perform specific functions in the support of other agencies' eligibility determinations regarding Medicaid-funded services and programs.

4.2 The Contractor will determine eligibility for BH, State-funded services and/or funding based on age, functional, diagnostic, and financial eligibility criteria applicable to the respective funding sources or programs.

4.2.1 The Contractor will apply DBHDD policy to determine eligibility for State-funded services.

4.2.2 Contractor will systematically validate an individual's financial eligibility for State-funded services.

4.2.3 Specifically, the Contractor will perform all or some of the following tasks to determine eligibility for **State-funded, BH** programs or services as required by each of the funding sources, programs, or services. Where functions are not currently active as of the execution of this contract, these functions may be implemented at a future date to be determined by DBHDD:

- 4.2.3.1 Maintain an online eligibility application with standardized criteria.
- 4.2.3.2 Conduct income verification for State-funded services as outlined in Section 15.3.1.4.1.
- 4.2.3.3 Verify an individual's eligibility and enrollment for State-funded programs.
  - 4.2.3.3.1 In collaboration with DBHDD and other State agencies (e.g., Department of Labor, Department of Revenue), support the verification of:
    - 4.2.3.3.1.1 Age and financial eligibility, if applicable.
    - 4.2.3.3.1.2 Diagnostic and function eligibility,
    - 4.2.3.3.1.3 Program eligibility, if applicable.
    - 4.2.3.3.1.4 Service eligibility, if applicable.
- 4.2.3.4 Enroll eligible individuals in State-funded services and supports, following DBHDD's eligibility determination.
- 4.2.3.5 Confirm that the eligibility and enrollment determination were

appropriately conducted.

4.2.3.6 Determine availability of third-party insurance coverage for all populations (e.g., Medicare, Tricare, Veteran's Administration benefits, commercial insurance).

4.2.3.7 Using available community resources, the Contractor will note when an individual is potentially eligible for Medicaid, but not enrolled in Medicaid, and prompt the referring Provider to facilitate Medicaid application and enrollment when an individual is potentially eligible for Medicaid but has not applied.

4.2.3.8 Accurately determine the amount of liability for services each Individual or Recipient will owe having applied a sliding fee scale, co-pay, or coordination with third-party benefits (see Section 15. Information Systems and Data Exchange for cross reference).

4.2.3.9 Review other qualifying characteristics for service eligibility (e.g., place of residence, membership in ADA target population).

4.3 The Contractor's role in assessing individuals for eligibility for **Medicaid-funded, BH** services includes:

4.3.1 The Contractor will verify Medicaid eligibility through GAMMIS.

4.4 The Contractor is responsible for coordinating the following eligibility determination activities and enrollment **for IDD** services with the following State agencies:

4.4.1 The regional I&E teams are responsible for intake and evaluation of individuals who apply for IDD Medicaid services, and for determination of functional eligibility for the Waiver programs. The eligibility and enrollment process is described in Sections 4.5 and 4.6 for information purposes only.

4.4.2 The regional I&E teams are responsible for eligibility determinations for State-funded community IDD services. Enrollment into community IDD services is the responsibility of the RO in accordance with State priorities for these services. DBHDD places a priority on serving individuals on the planning list for COMP/NOW services with State-funded community IDD services.

4.4.3 The State's DHS DFCS determines Medicaid financial eligibility.

4.4.4 The Contractor will verify Medicaid eligibility through GAMMIS.

5 Covered Benefits and Services

5.1 Medicaid Covered Benefits and Services

5.1.1 FFS Medicaid, BH covered benefits and services are delineated globally in the approved State Medicaid Plan Amendment, and more specifically in the DBHDD Provider Manuals.

5.1.2 HCBS for BH and IDD are delineated in their respective Waivers/funding authorities.

5.1.2.1 BH – no active waivers for BH at time of contract execution
5.1.2.2 IDD
5.1.2.2.1 HCBS for IDD are delineated in the COMP and NOW Waivers

5.2 Non-Medicaid Covered Services and Benefits

5.2.1 Georgia offers a State-funded system of services and supports for Individuals who have a BH condition not eligible for Medicaid benefits. These covered services and benefits are delineated in the Community BH Provider Manual.

5.2.2 Georgia offers some BH services to Medicaid-enrolled and State/grant-funded Individuals who qualify for those unique services (such as Supported Employment). Those covered services and benefits are delineated in the Community BH Provider Manual.

5.2.3 Georgia offers a State-funded system of services and supports for Individuals with IDD not eligible or waiting for Medicaid-funded services. Covered services and benefits are in the DBHDD Provider Manual for Community DD Providers in Appendix 1..

5.3 GCAL covered services include telephonic, text and chat crisis intervention, triage and referral services, and mobile crisis dispatch and monitoring. (See Section 6 and Appendix 23 for more information.)

6. **GCAL**

6.1 General Requirements

6.1.1. The Contractor will:

6.1.1.1. Assess an individual's needs using DBHDD approved assessment tools, protocols, and decision trees.
6.1.1.2. Identify the supports and services that are necessary to meet those needs.
6.1.1.3. Determine the severity and urgency of the needs.
6.1.1.4. Connect the individual to services consistent with the assessed level of severity and urgency in the most appropriate and least restrictive setting taking into account service and eligibility.
6.1.1.5. For Individuals already served in the DBHDD network, assist in reconnecting the Individual with his or her current or prior service Providers, or the designated RO and I&E as indicated, taking into account individual choice and expertise necessary to address individual needs.

6.1.2. The Contractor will collaborate with network providers, crisis service providers (e.g., mobile crisis, CSUs), Medicaid's CMOs and first responders (e.g., police, sheriff, fire, emergency medical, hospital emergency rooms, 911 call centers), taking into account potential funding sources (e.g., Medicaid FFS, private insurance, State-funded) to:

6.1.2.1. Stabilize individuals as quickly as possible and assist them in returning to their

pre-crisis level of functioning and environment, using telephone intervention, triage, and dispatch of MCTs, Assertive Community Treatment (ACT) teams (for ACT clients), or other first responders as indicated; and/or

6.1.2.2 Provide solution-focused, person-centered and/or recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, institutionalization, or out of home placement, implementing established crisis plans when available.

6.2 GCAL Operational Requirements

The Contractor will:

6.2.1. Operate a crisis and access center that is available at all times.

6.2.2. Provide live answer to all calls / text/ chat from persons in Georgia with a BH or IDD-related behavioral crisis, condition, or problem, regardless of individual resources.

6.2.3. Answer National Suicide Prevention Lifeline (Lifeline / or 988) calls routed from Lifeline or 988 either by phone, text, or chat 24 hours a day, 7 days a week within the existing metrics of the performance guarantees (appendix 42).

6.2.4. Answer calls directed to GCAL related to gambling and gambling issues. Keep current all resources for individuals reaching out with need for services related to gambling.

6.2.5. For purposes of cost efficiency, GCAL staff may be located in other U.S. state. The GCAL function must be primarily operated in Georgia. No more than 20% of GCAL staff (Tiers I-IV) can be located outside of the state of Georgia.

6.2.5.1. Staff members located in other states must receive sufficient training regarding GCAL policy and procedure that individuals will not notice a difference in the services delivered in or outside of Georgia.

6.2.5.2. For GCAL functions performed in another state, crisis intervention and triage must be coordinated with a local (Georgia-based) professional on-call for this purpose. This individual will consult regarding crisis interventions and referral plans for compatibility with Georgia geography, practice patterns, culture, and other relevant factors.

6.2.5.3. The same performance metrics apply regardless of the location of center operations.

6.2.6. Utilize DBHDD’s existing toll-free crisis and access line telephone number, unless otherwise approved by DBHDD.

6.2.7. Publicize the single toll-free crisis and access number throughout Georgia, and include it prominently on the Contractor’s website, Recipient and individual materials, provider resource directory, and as a listing in telephone books/listings. Include the phone number in all marketing materials (e.g., cards, magnets) for Providers, individuals, law enforcement, schools, and other partner agencies. These marketing materials should also be distributed in Spanish.

6.2.8. Offer culturally appropriate, and commonly used communication devices (those most frequently used by persons who are deaf such as Georgia Relay), interpretation, or language translation services to persons that do not speak or understand English and for the deaf and hard of hearing.

6.2.9. The Contractor's website must include key information regarding GCAL and provide that information in English and Spanish.

6.2.10. Upon DBHDD's request, the Contractor will operate two phone lines:

6.2.10.1. A public line for accessing routine, urgent, or emergency services.

6.2.10.2. A private line which provides a direct connection between GCAL and crisis and inpatient services Providers (e.g., emergency rooms, CSUs, MCTs, State hospitals) in order to coordinate referrals between parties.

6.3 GCAL Staffing

6.3.1 Crisis Intervention Specialists responsible for providing telephonic crisis intervention, triage, and follow-up. Crisis Intervention Specialists will include Crisis Counselors in four tiers:

Tier I:	Certified Peer Specialists or Bachelor's degree
Tier II:	Master's degree
Tier III:	Associate license
Tier IV:	Unrestricted/independent license

At all times, at least one crisis intervention specialist with experience conducting behavioral crisis intervention for individuals with IDD will be available as defined in Section 6. GCAL.

6.3.1.1. If out-of-state sites are utilized for GCAL services, the Contractor will hire staff to respond to the crisis line who meet staffing requirements as outlined above in 6.3.1. These individuals must, comply with all laws that govern professional practices for that state, meet experience and professional requirements comparable to Georgia's licensing laws, and successfully complete Employee training that ensures adequate knowledge of Georgia's BH and DD service delivery system and other community resources. (See Staffing Requirements in Administration Section 3.2.)

6.3.2. The Contractor will hire supervisors to provide live call monitoring for all crisis call responders, with an increased frequency of review for those without Georgia licenses.

6.3.3. Unless otherwise approved by DBHDD, all calls to the published GCAL number or forwarded from the National Suicide Prevention Lifeline will be live answered. Based on technology utilized, DBHDD will allowed the vendor to route calls from "safe" numbers such as known partners of providers, hospitals, etc. to be routed to trained staff for management.

6.3.3.1. The Contractor will hire a sufficient number of qualified staff to answer ninety-five percent (95%) of GCAL calls within thirty (30) seconds. (See PGs for more

information.)

6.3.3.1.1. At all times, at least one crisis intervention specialist who has experience conducting behavioral crisis intervention for individuals with IDD or dual diagnosis (i.e., BH and IDD) will be available for consultation by phone or on site.

6.3.3.1.2. The Contractor will hire, train, and make available at least one Certified Peer Specialist (CPS) with experience conducting BH crisis support for consultation by phone or on site

6.3.3.1.3. The Contractor's GCAL staff will complete annual competency-based training that addresses, at a minimum, suicide risk assessment, crisis intervention, crisis screening and response protocols, associated performance requirements, and other required functions. (See training requirements in the QM section.)

6.4 GCAL Crisis Line Technology

The Contractor will provide:

6.4.1 A telephone system with caller identification (caller ID) and routing technology

6.4.2 The telephone system will have the capacity for warm transfer, 3-way calling, and phone patches (as permitted by law).

6.4.3 On any call transferred to 911, the GCAL staff will remain on the line as long as necessary to assist and support the caller and 911 operator (i.e. warm transfer).

6.4.4 On any call transferred to other than 911, the GCAL staff will remain on the line until the person receiving the call indicates the GCAL staff member may disconnect (i.e. warm transfer).

6.4.5 The GCAL systems will support instant messaging and texting for both internal and external purposes utilizing HIPAA-compliant applications/technology.

6.4.6 GCAL systems will include a mobile crisis provider dispatch tracking system that captures documentation and recording of mobile crisis provider dispatch time by county, zone, and/or region and self-reported time of arrival, and disposition of mobile crisis response. (See Appendix 23, Sample GCAL Dashboards and Reports.)

6.4.7 The Contractor will facilitate and coordinate intensive and crisis BH, and IDD Crisis referrals using agreed upon technology of telephonic and web-based communications (e.g., email, instant messaging, texts).

6.4.8 The phone system will have the capacity for silent monitoring and access by call center supervisory and clinical-management staff to listen and participate in calls without interruption being certain that these applications are compliant with Georgia Law.

6.4.9 GCAL calls may be recorded. The Contractor must have policies and procedures

that are minimally compliant with the Health Insurance Portability & Accountability Act (HIPAA) regulations, 42 C.F.R. Part 2, and State law and address retention of records (see Section 18.1.7).

6.4.10 The Contractor will develop and implement a web-based live dashboard (Dashboard) showing bed capacity to facilitate secure communication and information sharing with specified referral sources (e.g., emergency rooms, agencies that review referrals for admission) to facilitate an efficient referral process and timely access to services (see Section 15.4.5) and Appendices 10 and 23 for information related to current processes.

6.4.10.1 The Dashboard will permit rights-based access to DBHDD staff, referral sources, and Georgia agencies that review referral information to make admission determinations.

6.4.10.2 Referral sources and agencies with whom the referral information is being shared will have access to the system to both upload and review information to facilitate an admission determination.

6.4.10.3 Referral source and agency actions will be automatically tracked and summarized in a report format (e.g., agencies that have submitted and agencies that have reviewed admission information, admission determinations for individuals, and in the aggregate) and included in Provider Performance Profiles as applicable.

6.4.10.4 The Dashboard will permit referral sources and agencies to access and modify information regarding bed capacity and census on as close to real-time basis as possible.

6.4.10.4.1 Bed capacity information will be time stamped and responses tracked.

6.4.10.4.2 Bed capacity and census will be summarized in a live “dashboard-report” format that permits easy determination of available beds and the status and basic demographics of those persons being served. (See screen shots of existing Dashboards in Appendix 23.)

6.4.11 The Contractor will update current technology to create and maintain service efficiencies.

6.5 GCAL Services

The Contractor will:

6.5.1. Provide triage, referral, and MCT dispatch services.

6.5.2. Provide telephonic, text or chat crisis counseling as indicated.

6.5.3. Dispatch first responders, mobile crisis services and ACT teams for individuals receiving ACT services as indicated.

6.5.4. Refer to appropriate facilities as determined by the need, diagnosis, and disability of the individual.

6.5.5. Track and monitor referrals on the bed board to resolution (e.g., acceptance),

implementing agreed upon escalation protocols as needed (including IDD Bed Board as described in Statement of Work dated 1/25/2018).

6.5.6. Provide telephone or text or chat support to callers to the crisis response line, including follow-up to those not requiring a mobile crisis response to ensure the individual is stabilized and the appropriate linkage was provided.

6.5.7. Implement crisis interventions and Provider referrals based on the individual's acuity and information contained in the client record (if applicable), including open authorizations and current Providers.

6.5.8. Work with Providers to develop mechanisms to connect the individual or Recipient to the Providers' on-call service when appropriate.

6.5.9. Operate the GCAL as the Preferred Point of Entry for State hospitals and CSUs and the Single Point of Entry for IDD crisis services.

6.5.10. Operate the GCAL as the Single Point of Entry for mobile crisis services (BH and IDD) and DBHDD-contracted inpatient psychiatric facilities for the uninsured. (See Appendix 9, Definitions.)

6.5.11. Callers determined to need these specific intensive services noted above (but not mobile crisis) will be reviewed by a GCAL clinical supervisor to confirm the most appropriate crisis service setting/modality has been made available.

6.5.11.1. For those persons referred and accepted into the CSU's and Contracted inpatient psychiatric hospitals, an authorization number will be assigned and provided to be used by the Provider, for billing purposes.

6.5.12. The Contractor will provide information and referral for appropriate services consistent with the policies, procedures, and requirements associated with the most likely funding sources for individuals with routine needs.

Specifically, the Contractor will provide the following referrals:

6.5.12.1. Referral for a BH assessment at an available approved network Provider for any potentially eligible Medicaid Beneficiary or non-Medicaid Beneficiary (see Eligibility and Enrollment in Section 4.1.–4.3.).

6.5.12.2. Referral for a SUD assessment at an available residential services Provider, if preliminary screening indicates such services may be required.

6.5.12.3. Referral for an evaluation with the appropriate Regional I&E for any potentially eligible Medicaid Beneficiary or non-Medicaid Beneficiary (see Eligibility and Enrollment, Section 4.1–4.4) requiring IDD services.

6.5.12.4. Referral for routine IDD needs to the appropriate Regional I&E within twenty-four (24) hours of request. (See DD Crisis Standards as found in DD Provider Manual.)

6.5.12.5. For urgent callers, referral to the MCTs for those seeking IDD services and supports. (See Appendix 1 DD Provider Manual.)

6.5.12.6. Provide information to individuals who do not appear to meet criteria for Medicaid or State-funded services to other available services and resources

(e.g., homeless shelters, United Way, domestic violence programs, Alcoholics Anonymous).

6.5.12.7. For routine needs After Hours, individuals will be provided Provider contact information for scheduling appointments with the Provider(s) of his or her choice.

6.5.12.8. For urgent needs, (if deemed appropriate) individuals will be assigned to pre-determined urgent appointments offered by a subset of network Providers. (Specified Providers will contract with the State to reserve time for urgent appointments at a certain time each day.)

6.5.12.9. For BH referrals for routine needs, the Contractor will offer a choice of Provider when more than one Provider is available and offer individuals assistance, via warm transfer to the Provider of his/her choice during regular business hours. The Contractor will provide the individual with the relative location of providers when choice is available.

6.5.12.10. For routine IDD needs, the Contractor will provide warm transfer to the appropriate Regional Field Office during business hours.

6.5.12.11. For routine IDD needs After Hours, the Contractor will inform the appropriate RO about the individuals' needs within one business day of the request.

6.6 GCAL Networking Requirements

6.6.1. The Contractor will develop and maintain collaborative relationships with:

6.6.1.1. Network providers.

6.6.1.2. Fire, police, sheriffs, emergency medical services, hospital emergency departments, CMOs, judges/courts, legal advocates, private in-patient facilities and providers of public health and safety services.

6.6.1.3. Regional and State offices.

6.6.1.4. CSUs and BHCCs.

6.6.1.5. Advocates and stakeholders, including peer-operated warm lines to allow warm transfers of calls between both call centers as appropriate.

6.7 GCAL Call Center Performance Metrics

6.7.1. Ninety-five percent (95%) of crisis calls answered live within thirty (30) seconds or less.

6.7.2. Call abandonment rate of < three percent (3%) for the crisis line.

6.7.3. Fewer than four (4) options on the automated call distribution (ACD) automated message for the private line.

6.7.4. Mobile crisis dispatch PMs. (See Appendix 18, PMs.)

6.8 The Contractor will produce monthly and annual (including year to date summary) GCAL Dashboards and reports (as well as some limited ad hoc reports) in the DBHDD-specified format to include, but not limited to:

6.8.1. Call volume and statistics by geographical region when applicable. (See example dashboards and reports in Appendix 23.)

6.8.2. Performance relative to GCAL call center performance metrics — both cumulative and by location.

6.8.3. Individual demographics (e.g., age, race, type, disability, etc.).

6.8.4. Origin of call, such as home, emergency room, community, day program, provider, parent, individual, etc.

6.8.5. Mobile crisis and ACT team dispatch, time of arrival, and disposition of response by region and zone. Call volume by call type (e.g., crisis, emergent, urgent, routine, IDD evaluation, informational).

6.8.6. Referral disposition summaries in a format to be approved by DBHDD.

6.8.7. Number of completed follow-up calls and results relative to the number of calls.

6.8.8. Critical incidents (e.g., suicide attempts, law enforcement dispatch).

6.8.9. Summary data regarding availability and information related to Intensive BH Services and admissions.

6.8.10. Service gaps or access barriers identified.

6.8.11. Analysis of calls, texts and chats with individuals, dispositions, call sources, referral sources, and other relevant information to make recommendations and assist the Department in improving its crisis response system.

6.7 The Contractor will provide DBHDD with all relevant GCAL reports as required in Appendix 26, Deliverables and Reports Matrix.

6.8 The Contractor will report to DBHDD regarding all relevant GCAL-related PMs in Appendix 18 and 42, PMs and PGs.

7 Network Management

7.1 General Requirements

7.1.1. In partnership with DBHDD, the Contractor's network management program will eliminate or reduce network-related barriers that impede Recipient and individual progress toward recovery and independence goals.

7.1.2. The Contractor will review applications for prospective agencies seeking to provide services as well as for existing Providers that request expansion, monitor network demand, conduct State and regional network adequacy analysis, maintain electronic Provider resource directories, identify service gaps, monitor Provider compliance with DBHDD and DCH network-related requirements, and provide DBHDD with network development assistance.

7.1.3. On behalf of DBHDD, and as relevant to this section, the Contractor will interact

with all Providers as DBHDD's administrative agent. DBHDD will maintain its role as the contracting authority with network Providers.

7.2 Operational Requirements

The Contractor will:

7.2.1. Conduct Medicaid and State Provider pre-qualifications reviews.

7.2.2. Perform HCBS provider qualification verification.

7.2.3. Provide technical assistance and training to Providers as indicated specific to enrollment requirements.

7.2.4. Maintain a complete and current Provider Network database that tracks, at a minimum, provider demographics, services approved, licenses, key staff, service sites, and counties served as well as status of accreditation and for some IDD Providers, their compliance with the standards review process.

7.2.5. Provide program oversight of the Georgia Housing Voucher (GHV) program as it relates to the following: landlord (LL) network management and data entry, LL network reporting and related activities, oversight and management of claims issues and activities, management of escalated issues with LL regarding claims and payment issues. Provide utilization management (UM) services, including the creation of authorizations for newly enrolled GHV recipients. Additionally, the contractor will prepare and render the Notice to Proceed (NTP) documentation and notify, in writing, the Individual, provider(s) and DBHDD, as appropriate, and via the method defined by DBHDD. The UM activities will be conducted for newly enrolled Individuals.

7.2.5.1 The anticipated annual volume for newly enrolled Individuals is approximately 1050 annually. The staffing is outlined in Georgia Hospital to housing (H2H) Proposal.

7.3 Medicaid and State-Funded BH and IDD Provider Prequalification

The Contractor will:

7.3.1 For Medicaid FFS and non-Medicaid (BH and IDD) Providers, the Contractor will host routine Provider fora in central locations to inform prospective providers of the application policies and procedures as well as information regarding services that are being highlighted for recruitment of providers. The Contractor will pre-qualify providers applying to deliver or expand covered services or sites to the BH and IDD populations.

7.3.2 To prequalify providers, the Contractor will validate the provider's submitted information relative to the DBHDD Policy and Medicaid State Plan qualifications under direction from DBHDD, in agreement with DCH.

7.3.3 Contractor will work collaboratively with designated DBHDD staff regarding site visits for specific services prior to recommending approval or denial.

7.3.4 The Contractor will develop and implement internal procedures and protocols that include the following:

7.3.4.1 Review of all provider qualification requirements for pre-qualification and Continued Qualification Requirements.

7.3.4.2 Set specific timelines for each segment of the reviews that will be approved by DBHDD, and no greater than the existing policy's current timelines.

7.3.4.3 Utilize standard communications with Providers regarding the status of their application(s) at each phase of the process as well as standard communication mechanisms to request additional information or clarification.

7.3.4.4 For providers who successfully complete the pre-qualifications and submit DBHDD and DCH applications, the Contractor will review completed applications (See Appendices 43, 44, 45, for information related to Provider Applications for BH and DD Service Providers) and attachments.

7.3.5 Upon completion, the Contractor will recommend to DBHDD and DCH for inclusion in the Provider Network enrollment of each Provider that meets qualifications.

7.3.6 The Contractor will also recommend Provider application denial decisions. For Providers who are denied, the Contractor must provide qualified staff to participate in any administrative hearings if the Provider appeals the denial.

7.3.7 The Contractor will establish an email address for communication with both prospective and existing Providers. It is expected that emails receive an individualized response within two (2) business days.

7.3.8 The Contractor will respond to questions and complaints from Providers regarding the network application and process with DBHDD-approved responses.

7.3.9 These communications will be routinely summarized and reported to DBHDD.

7.3.10 On an annual basis, the Contractor will identify Providers that do not meet specifically identified qualifications such as accreditation, licensing of specific staff and/or provide written confirmation to the State that Providers serving Medicaid and State-funded BH or I/DD individuals meet qualifications.

7.4 HCBS Provider and State-Funded IDD Provider Qualification verification

The Contractor will:

7.4.1 On an annual basis, verify HCBS Providers' qualifications as outlined in the HCBS authorities for each Provider type. (See Appendices 2 and 3, COMP Waiver and NOW Waiver).

7.4.2 To verify HCBS providers' qualifications the Contractor will conduct pre-qualification and Continued Qualification Requirements, consistent with the respective Waivers. (See Appendices 2 and 3 for waiver requirements;

Application information can be found in Appendices 43, 44, 45.)

7.4.3 In addition, confirm compliance with all other requirements of DBHDD and DCH as defined in the Medicaid State Plan and approved Waivers, consistent with the protocol developed in conjunction with DCH and its Medicaid management information systems Contractor.

7.4.4 Upon completion, recommend enrollment of each Provider meeting qualifications to DBHDD and DCH for inclusion in the Provider Network. DBHDD and DCH will complete the final review and determination.

7.4.5 On an annual basis, send written confirmation to the State that Providers serving Medicaid and State Individuals and Recipients meet Continued Qualification Requirements.

7.4.6 Notify DBHDD of the verification of all HCBS Provider qualifications on the aggregation schedule outlines in the Waiver Manual Parts 2 and 3.

7.5 Provider Resource Directory

The Contractor will:

7.5.1. Maintain a searchable, online, easy to use Provider Resource Directory that includes accurate and up-to-date information regarding DBHDD Providers.

7.5.2. The Provider Resource Directory must be able to be printed by users on demand.

7.5.3. Include all Provider types including professionals, agencies, support service providers, peer run organizations, etc.

7.5.4. Advertise the GCAL phone number and services.

7.5.5. Ensure Provider information is presented in a manner that helps Beneficiaries make informed choices regarding Provider selection and offers choice of Providers when available.

7.5.6. Update the online Provider Resource Directory within 1 business day of update such as a new provider, services, location, counties served.

7.5.7. The Provider Resource Directory will be organized/able to be filtered by population served (i.e., mental health (MH) only, SUD only, co-occurring MH and SUD, IDD only, and co-occurring BH and IDD, crisis, and emergency Providers (see Section 6. GCAL) and LOC, if applicable. Directory information will include, at a minimum:

7.5.7.1. Demographics (e.g., name, address, phone number, and map).
7.5.7.2. Logistical factors including public transportation accessibility and additional information related to accessing services.
7.5.7.3. Qualifications, specialties, populations served, and languages spoken.
7.5.7.4. A description of services offered and days and hours of service.
7.5.7.5. Performance profile information, as applicable.

7.6 Network Adequacy Assessment

7.6.1. As requested, the Contractor will assess and report on the size and scope of the State and regional Provider networks to assist DBHDD in determining network adequacy for providing HCBS, Medicaid FFS and State-funded BH and IDD services and supports, and the need for targeted Provider recruitment. This will include an analysis of all approved services/locations and an analysis of services provided (i.e., billed or reported).

7.6.1.1. The Contractor will identify service gaps by conducting geo-access analyses by Provider type and service category, including services, supports, and peer-run organizations, to ensure sufficient numbers of specific Provider types to serve all populations.

7.6.1.2. Report State prevalence rates for MI, SUD, and IDD by county.

7.6.1.3. Track and trend information on services requested, but not available. These analyses will be conducted utilizing network accessibility standards defined below.

7.6.1.4. Request information from relevant stakeholders regarding service availability.

7.6.1.5. Monitor and compare penetration rates by age, region, and ethnic/minority to provide information regarding network provider diversity needs.

7.6.1.6. Assist DBHDD in addressing deficiencies in the Provider Network by identifying potential providers, inviting them to submit a network Letter of Intent, and supplying information and technical assistance to those providers regarding the network enrollment process.

7.7 Network Accessibility

7.7.1. In agreement with DCH, Medicaid BH network accessibility requirements and monitoring are the responsibility of DBHDD. (See Appendix 18 for Medicaid PMs.)

7.7.2. In agreement with DCH, Medicaid HCBS network accessibility requirements and monitoring are the responsibility of DBHDD. (See Appendix 18 for sample HCBS PMs.)

7.7.3. The Contractor will monitor Provider adherence to the accessibility standards for State, Medicaid FFS and HCBS services and supports for which the contractor has responsibility for under the contract.

7.7.4. Current accessibility standards include, but are not limited to:

7.7.4.1. Providers' facilities are ADA compliant to include (e.g., handicapped parking and entrance ramps, wheelchair accommodating door widths, and bathrooms equipped with handicapped railing will be available for persons with a physical disability).

7.7.4.2. Language interpretation services are available by telephone or in person. Approved communication devices and interpreter services will be available for deaf and hard of hearing persons or those with a communication disorder.

7.7.4.3. Mobile crisis services response time standards.

7.7.4.4. Access standards to routine, urgent, and emergent appointments.

7.7.4.5. The Contractor will work with DBHDD to support Providers offering same day appointment goals.

7.7.4.6. When accessibility gaps are identified, marketing efforts, strategies, and timelines to engage new Providers will be proposed to and approved by DBHDD.

7.8 Network Adequacy and Accessibility PMs and Reports

7.8.1. The Contractor will provide DBHDD with an annual report that addresses the following, but is not limited to:

7.8.1.1. Provider prequalification and qualification verification activities and results.

7.8.1.2. Average time from receipt of completed application to verification across providers.

7.8.1.3. Network adequacy assessment results.

7.8.1.4. Identified service gaps.

7.8.1.5. Provider performance relative to access standards.

7.8.1.6. Contractor recruitment activities.

8 UM/UR

8.1 General Requirements

8.1.1. The Contractor will develop and implement an effective UM/UR Program for FFS Medicaid and non-Medicaid BH services and supports, HCBS services, and State-funded IDD services.

8.1.2. Contractor will participate in DBHDD UM/UR activities related to HCBS services and supports authorized

8.1.3. The Contractor will comply with all applicable DBHDD and DCH UM/UR requirements.

8.1.3.1. These requirements may change over time as DBHDD and DCH make system changes in response to QM findings, audits, stakeholder feedback, or changes in law.

8.1.3.2. The current UM/UR requirements and guidelines for BH services are embedded throughout the Community Behavioral Health Provider Manual. IDD UM/UR is primarily conducted through QEPRs and data analytics, as described in the QM section (Section 12) of this document.

8.1.4. The UM/UR Program will be designed to:

8.1.4.1. Provide effective and efficient utilization of resources;

8.1.4.2. Facilitate easy access to appropriate services;

8.1.4.3. Promote high quality care; and

8.1.4.4. Ensure Individuals receive the most appropriate, least restrictive, and most cost-effective recovery-oriented treatments and supports that meet their identified needs, and promote independence, consistent with their informed choices and preferences.

8.2 Contractor will develop and implement a UM/UR Program that:

8.2.1. Includes a UM/UR Program description, plan, and internal compliance policies and procedures that are consistent with DBHDD philosophy regarding UM/UR.

8.2.2. Documents the UM/UR program, goals, objectives, strategies, and activities.

8.2.2.1. By no later than January 31st of each calendar year, the Contractor will submit to DBHDD for approval a revised and updated UM/UR Program description and plan that incorporate and accommodate new initiatives requested by DBHDD.

8.2.3. Addresses the differing UM/UR requirements for each population served (e.g., FFS Medicaid BH, State-funded BH, HCBS and State-funded IDD); funding source eligibility and program requirements; and types of services reviewed.

8.2.4. Supports Providers in delivering evidence-based, person-centered, independence- and/or recovery-oriented, Medically Necessary, and cost-effective services and supports to Individuals and Recipients with minimal administrative barriers.

8.2.5. Employs UM/UR strategies including, but not limited to:

8.2.5.1. Prior authorization and Concurrent Review, to effectively manage Intensive BH Services. (Currently, IDD UM/UR is primarily conducted through QEPRs as described in the QM section (Section 12).)

8.2.5.2. In collaboration with DBHDD, consultation and technical assistance with Providers for which utilization patterns deviate from norms or practice guidelines or from recommended type, frequency, and/or intensity of services per individuals' service plans.

8.2.5.3. POC review for Individuals whose utilization patterns may indicate problems related to under-utilization as compared to Authorized Services or whose utilization of crisis services, emergency room or inpatient services is high with under-utilizing of community supports.

8.2.5.4. Eligibility verification, registration, LOC linkage to service authorizations, data analytics, outlier management and retrospective review to manage less intensive community BH services.

8.2.5.5. Retrospective review of HCBS claims reports to include comparison to Prior Authorization of services for the purpose of tracking the rate of service deauthorization by service, Provider, and individual outliers.

8.2.6. Facilitates data-informed decision-making related to service utilization, based on Practice guidelines, evidence-based practice, best practices, and resource allocation.

8.2.7. Collaborates with clinical decision-makers at the local level by informing and supporting recovery planning and facilitating access to needed services, supports, and resources.

8.2.8. Identifies individuals with co-occurring BH and DD and complex needs, indicating opportunities to enhance service planning and delivery for improved outcomes.

8.2.9. Implements UM/UR strategies to promote community tenure, reduce the need for higher LOC for which there is limited capacity, and improve access for Individuals most in need.

8.3 UM/UR Operational Requirements

8.3.1. Staffing

The Contractor will have:

8.3.1.1. A sufficient number of qualified and trained MH, addictive disease (AD), and IDD staff members to implement all UM/UR Program requirements

competently and on time. (See staffing requirements in Section 3.2. Administration Requirement and Training Requirements in Section 12. QM.)

8.3.1.2. A sufficient number of qualified and trained physician consultants and Allied Health consultants as applicable (e.g., physical therapist, speech therapist, dieticians, nurses) to implement UM/UR Program requirements including Peer Review, Adverse Action determinations (in accordance with Section 10, Complaints and Grievances), and appeals.

8.3.2. The UM/UR plan will:

8.3.2.1. Articulate processes to assess, plan, implement, measure, evaluate, monitor, and report on UM/UR activities directed toward improving:

8.3.2.1.1. The outcomes, quality of care, services, and supports provided.

8.3.2.1.2. Performance of community Providers.

8.3.2.1.3. Data integrity used in the UM/UR Program and activities, including data produced by the Contractor and data received, managed, and utilized by the Contractor from other sources (e.g., Providers, GAMMIS, and DBHDD).

8.3.2.1.3.1. The Contractor will implement automated processes to ensure data received from other sources are accurate, timely, and complete.

8.3.2.2. Include, but is not limited to the following components:

8.3.2.2.1. A description of data collection systems used to monitor and evaluate processes, services, supports, and resources including, but not limited to:

8.3.2.2.1.1. Results of inter-rater reliability testing with UM/UR staff;

8.3.2.2.1.2. Timeliness of notices of Adverse Actions;

8.3.2.2.1.3. Timeliness of Prior Authorization and Concurrent Review processes and decisions; and

8.3.2.2.1.4. Adverse Action and Appeal turnaround times.

8.3.2.2.2. UM/UR reports that are timely, meaningful, with actionable results that are compared to regional and national norms for distribution to DBHDD and the Contractor's staff, DBHDD, ROs, Providers, and other key stakeholders.

8.3.2.2.3. Strategies for identification of utilization patterns and trends, and inefficient coordination of services, supports, and resources for each of the following:

8.3.2.2.3.1. By demographic variables (e.g., age group, gender, race).

8.3.2.2.3.2. By specific Provider (e.g., Provider performance profiling).

8.3.2.2.3.3. By population served (e.g., MH, SUD,

I/DD, deaf/hard of hearing).

8.3.2.2.3.4. By funding source (e.g., Medicaid BH, non-Medicaid BH, State-funded IDD, etc.).

8.3.2.2.3.5. By Recipient (e.g., identification of high risk, intensive need) within each population served.

8.3.2.2.3.6. By service area (e.g., region)

8.3.2.2.3.7. By Service type.

8.3.2.2.3.8. By other variables, including but not limited to risk factors (i.e., homelessness, frequent readmissions) and class membership (e.g., ADA population, deaf services lawsuit).

8.3.2.2.4. Mechanisms to:

8.3.2.2.4.1. Measure Provider adherence to approved practice guidelines.

8.3.2.2.4.2. Assess the adequacy of discharge and community transition planning, identifying specific outcomes associated with discharge and transition planning.

8.3.2.2.4.3. Evaluate service and support access and coordination.

8.3.2.2.4.4. Provide performance feedback to Providers regarding utilization and profiling.

8.3.2.2.4.5. Identify, analyze, and track claims outliers for adherence to state HCBS and waiver requirements but do not unnecessarily add administrative burdens to the system.

8.3.2.2.5. Processes for delivery of Notices of Adverse Action (NOAA) determinations, Appeals and Fair Hearing support consistent with Medicaid requirements and approved by DBHDD.

8.3.2.3. The Contractor will conduct monthly, quarterly, and annual reviews of its UM/UR Program activities to include:

8.3.2.3.1. The Contractor will submit monthly UM/UR reports to DBHDD no later than the fifteenth day of each month.

8.3.2.3.2. The Contractor will submit quarterly UM/UR reports to DBHDD no later than thirty (30) days, following the end of each quarter.

8.3.2.3.3. The Contractor will submit the annual UM/UR report to DBHDD no later than forty-five (45) days after the end of each annual period specified by the DBHDD (e.g., calendar or fiscal year).

8.3.2.3.4. The Contractor will post public reports on its public website annually when requested by DBHDD.

8.3.3. Specifically, the Contractor will develop and effectively implement processes, and internal policies and procedures for the following:

8.3.3.1. A comprehensive UM/UR Program for State-funded and Medicaid-funded community BH services;
8.3.3.2. A focused UM/UR Program for HCBS (i.e., COMP, NOW) and State-funded IDD services; and
8.3.3.3. UM/UR activities for Individuals with co-occurring BH disorders and IDD, consistent with funding-source rules and requirements.

8.3.4. The Comprehensive UM/UR program for BH services will include, at a minimum:

8.3.4.1. Case-specific UM/UR, electronic registration, electronic authorization, telephonic and electronic Prior Authorization, telephonic and electronic continued care reviews, and paper-based (on site) and electronic retrospective reviews that include Medical Necessity review, when applicable.
8.3.4.2. The Contractor will conduct all case specific BH UM/UR activities consistent with:
8.3.4.2.1. The Recipient's diagnosis and functional assessment;
8.3.4.2.2. The service(s) requested or needed, and the degree to which they are tied to the assessment;
8.3.4.2.3. Medical Necessity criteria;
8.3.4.2.4. LOC criteria;
8.3.4.2.5. Funding source eligibility criteria, rules, and regulations;
8.3.4.2.6. Medicaid rules and regulations (if applicable), and
8.3.4.2.7. DBHDD requirements (if applicable).
8.3.4.3. The Contractor will use DBHDD-approved BH and LOC, UM, and UR criteria, when applicable. (See Community BH Provider Manual in Appendix 6 for required UM/UR criteria as presently written. As indicated in Background section, these criteria are subject to change.)
8.3.4.3.1. At least annually, the Contractor will make recommendations to DBHDD for updating UM/UR criteria with input from Providers, Recipients, and national experts as described in Section 12. QM.
8.3.4.4. The Contractor will review BH services for Fraud and Abuse consistent with Section 3.3. Compliance.
8.3.4.5. The Contractor will assist in identifying and noting prominently in the client's record for Providers and DBHDD when an individual is potentially eligible for Medicaid, but not applied or is not enrolled.
8.3.4.6. For less intensive BH services, the Contractor will utilize the following procedures for case-by-case BH UM/UR:
8.3.4.6.1. Conduct non-Medicaid eligibility determinations and verifications consistent with the requirements in Section 4. Eligibility and Enrollment.
8.3.4.6.2. Register individuals seeking any service, which at a minimum, includes the assignment of a unique consumer identification number (CID).
8.3.4.6.2.1. For individuals seeking emergency services through GCAL, and when the call is urgent

or otherwise warrants immediate action and the collection hinders the success of a referral, consumer information may not be required and “Registration Information” may *only* consist of the CID.

8.3.4.6.3. Authorize less intensive BH services using a web-based authorization system that addresses all of the authorization processes and components in the Provider manual (see Appendix 6, Community BH Provider Manual). DBHDD reserves the right to reject Offeror’s proposal for less Intensive BH Services authorization processes and will revert to package authorization system if the proposal is not acceptable. (See Section 15.4. for specific Authorization system components.)

8.3.4.7. The Contractor will conduct Prior Authorization and/or Concurrent Review for Intensive BH Services which include the following:

8.3.4.7.1. DBHDD-contracted inpatient psychiatric services (not for Medicaid inpatient psychiatric services).

8.3.4.7.2. Intensive community residential services, including:

8.3.4.7.2.1. CSUs.

8.3.4.7.2.2. PRTF.

8.3.4.7.2.2.1. Medicaid and State-funded Community Residential Rehabilitation services paid on a per diem basis.

8.3.4.7.2.2.2. Residential SUD treatment and supports.

8.3.4.7.2.2.3. Medically Supervised Detox

8.3.4.7.3. Out-of-clinic BH intensive outpatient services, including:

8.3.4.7.3.1. ACT

8.3.4.7.3.2. Community Support Team 8.3.5.7.3.3. Intensive Case Management 8.3.5.7.3.4. Intensive Family Intervention.

8.3.4.7.4. In-Clinic BH intensive outpatient services, including:

8.3.4.7.4.1. Psychosocial Rehabilitation Programs.

8.3.4.7.4.2. Peer Support Programs.

8.3.4.7.4.3. MH/SA Intensive Outpatient Programs

8.3.4.7.5. Other services for which there has been identification by the Contractor or DBHDD utilization trends that require additional scrutiny.

8.3.4.8. Components of the BH Prior Authorization and the Concurrent Review process will include:

8.3.4.8.1. Verification of the eligibility of the intended Recipient for services.

8.3.4.8.2. Verification that the Provider to whom payment would be made is qualified to provide the authorized service and eligible for payment.

8.3.4.8.3. Application of UR criteria that permits consideration of the presence of co-occurring disorders, culturally relevant factors, and the quality and availability of existing or potential community supports.

8.3.4.8.4. Requests by the Contractor that emergency departments involve a MCT in order to evaluate the possible diversion of

Recipients from inpatient admission to community-based care, if it seems likely that such an intervention will succeed and the emergency room or facility agrees.

8.3.4.8.5. All decisions made by the Contractor to authorize non-Medicaid Beneficiaries' inpatient services will conform to the State's definition of Medical Necessity.

8.3.4.8.5.1. If the Medical Necessity definition conflicts with UR criteria, the State's Medical Necessity definition will prevail, and the Contractor will notify DBHDD of such conflict.

8.3.4.8.6. Prior to issuing a denial, the Contractor will conduct Peer Review for any Prior Authorization request that fail to meet LOC or admission criteria in the judgment of the Care Manger.

8.3.4.8.6.1. The Peer Review will be a peer of the requesting Provider and/or licensed as a physician or psychologist in the state in which the Peer Reviewer is located.

8.3.4.8.6.2. To the extent possible, the Peer Reviewer will have specialty expertise applicable to the Peer Review decision for the specific individual seeking services (e.g., addiction services, child versus adult).

8.3.4.8.7. The Provider will designate the appropriate individual to represent the Practitioner in the Peer Review process. The Provider will not be required to submit additional written documentation for this Peer Review.

8.3.4.8.8. The Contractor will offer an appointment to Providers for Peer Review to take place within one hundred and twenty (120) minutes of the completion of the Care Manager review for all requests for CSU and DBHDD contracted psychiatric inpatient services and medically-supervised detoxification services.

8.3.4.8.9. The Contractor will base its determination on peer desk review if the Provider requests not to participate or is otherwise unavailable to participate in a Peer Review.

8.3.4.9. Prior Authorization and Concurrent Review PMs. The Contractor will:

8.3.4.9.1. For inpatient services, CSU, and Medically-supervised detoxification services:

8.3.4.9.1.1. Offer twenty-four (24) hours a day, seven (7) days a week admission reviews (consistent with details in Section 6. GCAL) via telephone and web-based communication.

8.3.4.9.1.2. Render a Prior Authorization decision within thirty (30) minutes of receipt of a

web-based request and/or within (30) minutes of conducting a telephonic Intensive BH Services Prior Authorization review when the Care Manger determines that the Individual meets LOC and admission criteria.

8.3.4.9.1.3. Initiate a Peer Review immediately upon an assessment by the Care Manger that the person does not appear to meet LOC and/or admission criteria.

8.3.4.9.1.4. For those requests requiring a Peer Review, conduct the Peer Review and render a decision within one hundred and twenty (120) minutes of the initiation of the Peer Review process.

8.3.4.9.1.5. Times are measured from the time the Contractor receives all information deemed reasonably necessary and sufficient to render a decision, or for cases referred for Peer Review, from the time of the initiation to the completion of the Peer Review.

8.3.4.9.2. For the BH and SUD residential services and State-funded residential placements listed above:

8.3.4.9.2.1. Render Prior Authorization decisions within two (2) business days of receiving a web-based request, including the time for Peer Review.

8.3.4.9.3. For the remainder of the BH and SUD services listed above:

8.3.4.9.3.1. Render Prior Authorization decisions within five (5) business days of receiving a web-based request, including the time for Peer Review.

8.3.4.9.4. The Contractor will conduct periodic reviews of authorized BH services for timely and coordinated discharge and transition planning as part of Concurrent Review and report on the percentage of cases with adequate and timely coordinated discharge and transition plans.

8.3.4.10. Denials, actions, and Notices of Adverse Action (NOAA)

8.3.4.10.1. Adverse Actions may only be made by an appropriately licensed clinician, consistent with the credentials of the Practitioner delivering the services.

8.3.4.10.2. For example, services with a medical component (e.g., BH inpatient services) may only be denied by a psychiatrist or American Society of Addiction Medicines certified

physician); services which are clinical in nature may only be denied by Certified Addiction Counselor (CAC II or equivalent) or independently licensed clinician.

8.3.4.10.3. When the Contractor denies an Authorization request for a Medicaid-funded service, the Contractor will deliver a NOAA to Providers and Recipients consistent with regulatory requirements at 42 CFR 431, et al and DBHDD or DCH policies and procedures. The format and content of the NOAA will be prepared and/or approved by DBHDD legal services.

8.3.4.10.4. Performance requirements: The Contractor will render an Adverse Action determination and NOAA in accordance with the time frames set forth in Medicaid rules and regulations. Specifically, the Contractor will:

8.3.4.10.4.1. Render a verbal Adverse Action determination for Medicaid-funded BH services within (60) sixty minutes of completing the Authorization review.

8.3.4.10.4.2. Render a written NOAA that complies with 42 CFR 431 Subpart E and includes:

8.3.4.10.4.2.1. The reasons for the intended Adverse Action.

8.3.4.10.4.2.2. The specific regulations that support, or the change in federal or State law that requires the Adverse Action.

8.3.4.10.4.2.3. An explanation of:

- The Recipient's right to request an evidentiary hearing if one is available or a State Fair Hearing.
- In cases of an Adverse Action based on a change in law, the circumstances under which a State Fair Hearing will be granted.
- An explanation of the circumstances under which Medicaid services are continued if a State Fair Hearing is requested.

8.3.5. The focused UM/UR Program for Medicaid-funded HCBS services (i.e., COMP, NOW)

and State-funded IDD services will include the following components. The Contractor will:

8.3.5.1. Ensure that a service delivery monitoring function is in place that maintains financial accountability comparing GAMMIS claims payment data to services that are authorized and are furnished to Individuals by qualified HCBS Providers.

8.3.5.2. Conduct ongoing monitoring of HCBS Waiver and State-funded Providers' billing, claims paid by GAMMIS and data from the Contractor's database to ensure that supporting documentation is maintained and claims reimbursement is consistent with the Individual's POC and ISP.

8.3.5.3. Include processes to systematically identify, monitor, evaluate, and effectively intervene and/or report to DBHDD over- and under-utilization or inefficient coordination of services, supports, and other resources based on QEPRs, and other data.

8.3.5.4. Conduct analysis and reports that compare authorized HCBS services to claims/utilization to identify under-utilization at both the Individual and service level.

8.3.5.5. In addition, for UM/UR for State-funded IDD services only, the Contractor will:

8.3.5.5.1. Track standards of promptness pursuant to DBHDD policy and required functions for State-funded services.

8.3.5.5.2. Support any RO reviews of State-funded IDD ISPs consistent with State guidelines.

8.3.6. For UM/UR of housing, bridge and transition funding, the Contractor will:

8.3.6.1. Develop a single streamlined, online authorization system and receipt collection process for housing, transition, and bridge funding. (See Section 15. IS and Data Exchange.)

8.3.6.2. The Contractor will:

8.3.6.2.1. Review all State authorizations and payments for accuracy and consistency;

8.3.6.2.2. Develop a list of new registrations;

8.3.6.2.3. Confirm the list of past approved rental assistance commitments; and

8.3.6.2.4. Issue approval for Claims staff to invoice the State.

8.3.7. The Contractor will implement specific UM/UR strategies for Individuals with co-occurring BH disorders and IDD. These strategies will include, at a minimum:

8.3.7.1. Mechanisms to identify and readily recognize (in the information system) Individuals with co-occurring BH conditions and IDD.

8.3.7.2. UM/UR strategies implemented consistent with the requirements, rules, and regulations associated with the respective service funding sources.

8.4 Provider Technical Assistance and Education

8.4.1. The Contractor will maintain a systematic process for educating Providers about utilization issues, providing training and technical assistance regarding HCBS requirements, UM/UR criteria, and Practice Guidelines and other topics. Specifically, Provider education and training may include:

8.4.1.1. National trends and changes in nationally accepted practice guidelines.
8.4.1.2. Relevant service authorization processes and UM/UR criteria.
8.4.1.3. Compliance with regulatory requirements, performance standards, and DBHDD guidelines relative to the associated service-funding sources.
8.4.1.4. Requirements that appropriate services are authorized and delivered by qualified Providers, on a timely basis, consistent with an Individual's ISP and approved services delivered within service definition specification.
8.4.1.5. Provider profiles and Provider performance.

8.4.2. Provider technical assistance, education, and training may be provided via telephone, face-to-face and videoconference meetings, webinars, online video library/archived webinars, mailings, and other written information as indicated. (See Training in Section 12. QM for more information.)

8.5 PMs, Data Management, and Reporting

8.5.1. Provider Profiles

8.5.1.1. The Contractor will collect and analyze the non-HCBS UM/UR data and compile it into the Provider Performance Profile.
8.5.1.2. The Contractor will collect and analyze the HCBS UM/UR data and compile into the Provider Performance Profile. Where providers participate in both Medicaid and non-Medicaid service delivery, the Provider Performance Profile may reflect service data by type and/or fund source.
8.5.1.3. The profile will compare performance to normative data or national benchmarks, when applicable.
8.5.1.4. The Provider UM/UR performance profiles will be made available to QM for incorporation into Provider performance profiles and onsite reviews (e.g., QEPRs, and BH audits).
8.5.1.5. Portions of the Provider Performance Profile will be included in the online Provider Resource Directory.
8.5.1.6. GCAL and UM/UR staff will utilize the Provider Performance Profiles to inform referral and review functions.
8.5.1.7. Provider Performance Profile elements will include, but are not limited to:
8.5.1.7.1. Provider demographic information.
8.5.1.7.2. Population served, including volume.
8.5.1.7.3. Utilization measures across Individuals or Recipients by LOC or service, as applicable, which may include:
8.5.1.7.3.1. Average length of stay/average number of services.
8.5.1.7.3.2. Average cost of services per Individual/Recipient
8.5.1.7.3.3. Denial rate/unsuccessful appeal rate.
8.5.1.7.3.4. Percentage utilization of Authorized Services.

8.5.1.7.3.5 Number of admissions.
8.5.1.7.3.6 Number of admissions refused.
8.5.1.7.3.7 Number of discharges.
8.5.1.7.3.8 Readmissions within seven (7) and thirty (30) days.
8.5.1.7.3.9 Percentage of time a bed is available.
8.5.1.7.3.10 Planning list and/or wait list length.
8.5.1.7.3.11 Compliance with access standards.

8.5.2 UM/UR PMs

8.5.1.8. The Contractor will have mechanisms to monitor the performance of UM/UR staff, including, but not limited to:
8.5.1.8.1. Timeliness of UM/UR decisions and Peer Review.
8.5.1.8.2. Inter-rater reliability of UM/UR criteria application.
8.5.1.8.3. Compliance with NOAA requirements.
8.5.1.8.4. Documentation completeness.
8.5.1.8.5. Compliance with training requirements.

8.5.3 Reports

The Contractor will conduct and submit monthly, quarterly, and annual UM/UR reports (listed in Appendix 26, Deliverables and Report Matrix and outlined in Appendix 25, Sample description of BH & DD report parameters) that summarizes, at a minimum:

8.5.3.1 Standard utilization reports
8.5.3.2 Patterns of over- and under-utilization that provide:
8.5.3.2.1 Opportunities to promote efficiency, improve quality of care, or improve outcomes for Individuals and Recipients.
8.5.3.2.2 Opportunities to promote efficiency, improve quality of care, or improve outcomes for Providers.
8.5.3.3 The HCBS UM/UR results and identification of over- or under-utilization.
8.5.3.4 Performance relative to PM and PG standards in Appendices 18 and 42.
8.5.3.5 The degree to which discharge and transition planning is coordinated. (See Section 10. Complaints and Grievances.)
8.5.3.6 Prescription medication use utilization patterns and trends for Medicaid Recipients.
8.5.3.7 Provider technical assistance and training themes.
8.5.3.8 Summary, recommendations, and action plan.

9. PASRR

9.1 General Overview and Requirements

9.1.1. Medicaid regulations require States to maintain a Preadmission Screening and Resident Review (PASRR) program to screen nursing facility applicants and residents for suspected or confirmed diagnoses of mental illness (MI), intellectual disability (ID) and/or a related condition. The goal of PASRR is to identify individuals with one of these conditions, screen appropriateness for nursing facility care, and ensure provision of specialized services.

9.1.2. Federal regulations stipulate that the implementation of a PASRR program be a two-

level process. All Level I screenings which suspect mental illness or intellectual disability will automatically trigger a more in-depth evaluation, a Level II, which more accurately identifies mental illness and assesses whether the individual needs specialized services and nursing facility level of care. Individuals identified by the Level I screening are referred to the second level of the process; the Level II evaluation and determination of need for specialized services during their nursing facility residency.

9.1.3. There are two types of Level II evaluations: the Preadmission Screening (PAS) and the Resident Status Change Review.

9.1.3.1. The PAS is completed on individuals applying for admission to a Medicaid-certified nursing facility. Based upon FY13 data, an annual estimate of the number of performed PAS is 900.

9.1.3.2. The Resident Review is completed on any resident of a Medicaid-certified nursing facility when his/her status appears to have changed. Based upon FY13 data, an annual estimate of the number of performed Record Reviews is 250.

9.1.3.3. Prior to either type of Level II evaluation, each individual will be assessed using a clinical records review process.

9.1.4. The Department of Community Health is responsible for ensuring prior authorization of all admissions to Medicaid-certified nursing facilities, including determination of the need for nursing facility level of care, completion of the Level I screening, and PAS (and certain Resident Status Change Reviews) Level II referrals.

9.1.4.1. The DCH currently accomplishes the Level I responsibility through a contract (currently held with Alliant/GMCF).

9.1.4.2. The DCH accomplishes the Level II responsibility through the DBHDD as the partnering state mental health/ID authority for the PASRR program. DBHDD is responsible for ensuring the appropriate completion of all Level II evaluations through this procurement.

9.2 PAS Level II Evaluation

9.2.1. The DBHDD requires the Contractor to conduct PASRR Level II assessments of persons with suspected or confirmed diagnoses of mental illness (MI), intellectual disability (ID) and/or a related condition (RC) who are seeking admission to or residing in Medicaid-certified nursing facilities in Georgia.

9.2.1.1. The Contractor will partner with the PASRR Level I vendor and nursing facilities to receive content which triggers a Level II PASRR.

9.2.1.1.1. The Contractor will conduct and determine the outcome of a clinical records review within 48 hours of the date of transmission of the referral, including the date of transmission. If a PAS or Resident Status Change Review is required, this time frame shall count towards the nine (9) working days from the ALLIANT/GMCF referral.

9.2.1.1.2. Notify ALLIANT/GMCF of the outcome of clinical record review by the end of 48 hours following the date of the L2 disposition

9.2.1.1.3. The Contractor must notify ALLIANT/GMCF, the applicant and the resident of his/her legal representative, the referring hospital (if applicable) and/or the nursing facility (once admission has occurred) in writing of all evaluation outcomes, including when halted, deferred, or approved without specialized services no later than 5:00pm of the tenth (10^{th}) working day.

9.2.1.2. The Contractor will conduct Level II PASRR in compliance with federal regulations and requirements in Appendix 28 (Regulations issued by the Center for Medicaid and Medicare Services (CMS), Federal Code Regulations (CFR) 42, Part 483:100-136, Subpart C, under the auspices of the U.S. Department of Health and Human Services (http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol5/pdf/CFR-2010-title42-vol5-sec483- 100.pdf).

9.2.1.2.1. The Contractor must complete psychological and functional evaluations when not available or when not current. Psychological evaluations, including intelligence testing, of consumers with intellectual disability below the age of 18 must be current within three years for persons under the age of 18 years. Following initial eligibility determination for persons 18 years or older, psychological evaluations are to be conducted as needed in instances including but not limited to deteriorating neurological functioning, mental illness, severe unusual behaviors, and significant decline in everyday functioning.

9.2.1.2.2. For individuals diagnosed with ID, a report of measurement of intelligence must be part of the psychological evaluation and must be signed or counter-signed by a licensed psychologist. Appropriate standardized evaluation instruments recognized by professional organizations must be used. All evaluations completed by the Contractor on individuals with ID must contain the most recent psychological evaluation available, with appropriate signatures.

9.2.1.2.3. A functional evaluation is a basic component of the Level II evaluation instrument and must be performed on all individuals assessed. For individuals with mental illness, the functional evaluation will be performed by a qualified mental health professional. For individuals with ID or a related condition, a licensed psychologist or a qualified ID professional with experience or training in performing functional evaluations will perform the functional evaluation.

9.2.1.2.4. The Contractor will schedule and conduct PAS evaluations during reasonable hours (excluding legal

holidays) that accommodate the needs of the facility staff, the individual and his/her family.

9.2.1.2.5. The Contractor evaluator will obtain from the applicant, attending physician, hospital (if applicable), family members, or other appropriate contact persons all relevant medical records and any other pertinent information necessary to complete the evaluation, including a recent (within 1 year) medical history and physical examination report signed by a physician or by a nurse practitioner or physician's assistant, working under a collaborative protocol with a physician.

9.2.1.2.6. Ensuring all assessments/evaluations are adapted to the cultural background, language, ethnic, origin and means of communication used by the individual being evaluated.

9.2.1.3. The Contractor will hire and train qualified staff to conduct PASRR Level II PAS and the resident status change reviews as defined herein.

9.2.1.3.1. Contractor will recruit, train, and retain a sufficient number of registered nurses, licensed psychologists, physicians and qualified mental health and qualified developmental disability professionals (assessors) who are licensed/credentialed in Georgia to ensure that minimum requirements for conducting preadmission screening (PAS) and resident reviews (RR) for content, timeliness and signatures are met.

9.2.1.3.2. During the implementation period, the Contractor must submit a staffing plan that includes a description of credentials and licenses.

9.2.1.3.3. The Contractors will hire and retain PASRR clinical staff who are licensed in Georgia (as required by the respective professional practice acts) as a Physician, Psychologist, Social Worker, Professional Counselor, or Marriage & Family Therapist and based in Georgia.

9.2.1.4. The Contractor will document and convey Level II findings to DCH's PASRR Level I vendor (currently Alliant/GMCF).

9.2.1.4.1. The Contractor will produce and retain a summary of findings which:

9.2.1.4.1.1 is based on either on-site evaluations or record review and, using the PAS criteria;

9.2.1.4.1.2. documents findings for both categorical and individualized determinations that correspond to the person's current functional status as documented in medical and social history records;

9.2.1.4.1.3. confirms the decision by made ALLIANT/GMCF that the individual meets

criteria for nursing facility level of care, or provides specific evidence that the individual does not meet the criteria.

9.2.1.4.1.4. determines whether the individual has MI, ID and/or a related condition as defined in the federal regulations, and if so, whether the individual requires specialized services or rehabilitative services of a lesser intensity than specialized services.

9.2.1.4.1.5. Services and subsequent recommendations will be discussed with nursing facility staff, modified as appropriate, and documented in the Summary of Findings.

9.2.1.4.1.6. On all evaluations where it is determined that the individual requires a nursing facility level of care but does not need specialized services, the Contractor will determine the need for rehabilitative services of a lesser intensity than specialized services and make treatment recommendations. Services and subsequent recommendations will be discussed with nursing facility staff, modified as appropriate, and documented in the Summary of Findings.

9.2.1.4.2. The Contractor will be responsible for providing the Summary of Findings to ALLIANT/GMCF no later than 5 p.m. on the tenth (10^{th}) working day following the date of ALLIANT/GMCF referral.

9.2.1.4.3. The Contractor will be responsible for all written notification of evaluation outcome, including when halted, deferred, or approved without specialized services, according to federal regulations (42CFR 483:130). Written notification will include a cover letter and the Summary of Findings. Written notification will be sent to the applicant and the resident or his/her legal representative, the referring hospital (if applicable) and the nursing facility (once admission has occurred).

9.3 Resident “Status Change” Review

9.3.1 The Contractor will perform a Resident Review evaluation for any nursing facility (NF) resident suspected of or diagnosed as having MI, ID and/or a related condition, whose functioning status appears to have changed. This person must meet the criteria for a Resident Review evaluation as determined by the Clinical Records Review unless the person falls into an advance group determination as specified in 42CFR 483.130.

Resident Reviews are initiated by the nursing facility.

9.3.1.1. The content of the Resident Review evaluation will conform to PASRR regulations.

9.3.1.2. The Contractor will prepare and retain, for each evaluation initiated, a Summary of Findings in an approved format.

9.3.1.3. For those evaluations that require visits to NFs, the Department expects the Contractor to schedule and conduct all Resident Review evaluations during reasonable hours (excluding legal holidays) that accommodate the needs of the facility staff, the individual and his/her family.

9.3.1.4. The evaluator will obtain from the applicant, attending physician, facility, family members, or other appropriate contact persons all relevant medical records and any other pertinent information necessary to complete the evaluation, including a recent (within 1 year) medical history and physical examination report signed by a physician or by a nurse practitioner or physician's assistant, working under a collaborative protocol with a physician.

9.3.1.5. The Contractor will document the result of the Resident Review in a summary of findings which:

9.3.1.5.1. will document findings that correspond to the person's current functional status as documented in medical and social history records.

9.3.1.5.2. will reaffirm that the individual meets criteria for nursing facility level of care or provide specific evidence that the individual does not.

9.3.1.5.3. will determine whether the individual has MI, ID and/or a related condition as defined in the federal regulations.

9.3.1.5.4. will specify whether the individual requires specialized services or rehabilitative services of a lesser intensity than specialized services.

9.3.1.6. The Contractor will notify the Department on all evaluations where it is determined that the current nursing home resident does not require nursing facility level of care.

9.3.1.7. On all evaluations where it is determined that the individual requires a nursing facility level of care but does not need specialized services, the Contractor will determine the need for rehabilitative services of a lesser intensity than specialized services and make treatment recommendations. Services and subsequent recommendations will be discussed with nursing facility staff, modified as appropriate, and documented in the summary of findings.

9.3.1.8. The Contractor will be responsible for providing the Summary of Findings to ALLIANT/GMCF no later than 5 p.m. on the ninth working day following the date of ALLIANT/GMCF referral.

9.3.1.9. The Contractor will be responsible for all written notification of evaluation outcome, including when halted, deferred, or approved without specialized services, according to federal regulations (42CFR 483:130).

9.3.1.9.1 Written notification will include a cover letter and the

Summary of Findings.

9.3.1.9.1 Written notification will be sent to the applicant and the resident or his/her legal representative, the referring hospital (if applicable) and the nursing facility (once admission has occurred). The full evaluation will be sent to the nursing facility, if requested.

9.3.1.9.2 All written notifications will be postmarked on the date of determination or no later than 5:00 p.m. on the tenth (10^{th}) working day following the date of ALLIANT/GMCF referral.

9.4 Other Requirements

9.4.1 The Contractor will manage all out of state referrals of individuals who reside in another state and apply for nursing facility admission in Georgia. The Contractor will contact the home state and request the home state's Level II evaluation or request the home state to use the Contractor's evaluation tool for a Level II evaluation. The Contractor will complete the PAS evaluation process, produce the final Summary of Findings, and notify all interested parties as described above.

9.4.2 For interstate placement of an individual who resides in Georgia and applies for nursing facility admission outside Georgia, the state agency having authority for PASRR in the state in which the individual has applied for nursing facility placement will request via phone, mail, or fax, that the DBHDD complete a PASRR evaluation on an individual who resides in Georgia. The DBHDD will authorize the evaluation and refer it to the Contractor. After receiving the full Level II evaluation from the Contractor, the Department will deliver the evaluation, as requested, to the receiving state's PASRR agency. The receiving state will make a determination based on the evaluation.

9.4.1.1. Secured telemedicine is an option for these reviews.

9.4.1.2. An annual estimate for Out-of-State Evaluations is 10.

9.5. Administrative Requirements

9.5.1. The Contractor's PASRR operations must be available for receiving referrals during normal business hours (8:30am to 5:00pm) each day with the exception of official legal holidays. These may be separate or an integrated part of the Contractor's proposed call center.

9.5.2. The Contractor must ensure that it maintains the ability to provide evaluations in all counties of the State.

9.5.3. Maintain complete documentation verifying each assessor's qualifications and training, including the results of a criminal records check for Employees or subcontractors who will have direct contact with nursing facility residents (see the Department's Criminal History Record Checks policy located at https://gadbhdd.policystat.com/policy/201763/latest/

9.5.4. Provide training and technical assistance to nursing facility staff and nursing home association as identified by the Contractor, the Department, and/or the DCH on procedures to be followed in the PASRR Level II process. This assistance shall include periodic phone assistance and at least one (1) statewide training seminar with distributed training materials.

9.5.5. Establish and maintain electronic prior authorization systems for Level II screening and specialized services including but not limited to:

9.5.5.1. Completion of technical requirements and testing of prior authorization system.

9.5.5.2. Generation of and electronic transmission of the outcome determination for all Level II screens to Alliant/GMCF and to the MMIS (Level II Prior Authorizations in either “Approved” or “Denied” status indicating approval/disapproval for admission to a nursing facility).

9.5.5.3. Maintaining a web-based system for DCH PASRR behavioral health specialized services providers to request prior authorizations according to established protocol. These may include a small number of providers who are not a part of the DBHDD provider network (currently there are 2 PASRR behavioral health providers who are not DBHDD network providers).

9.5.5.4. Generation of and electronic transmission of prior authorizations for behavioral health Specialized Services to the MMIS.

9.5.5.5. Managing a website for nursing facility providers to verify Level II the status of Level II screening and results prior to nursing facility admission.

9.5.5.6. Collecting and analyzing MMIS response files and extracts from interfaces and report out trends and findings to DBHDD and DCH.

9.5.5.7. Meeting with DBHDD, DCH, and with other stakeholders on a quarterly basis to review processes and outcomes as part of a quality assurance process.

9.5.5.8. Providing technical assistance and training to providers as needed to facilitate access to the web-based system of prior authorizations.

9.5.5.9. The Contractor will be requested by the DBHDD to conduct additional evaluations for the purposes of verifying disputed findings, resolving complaints, and presenting the Department’s case in appeals hearings.

9.5.5.9.1. The Contractor will be responsible for coordinating the hearing process with the Office of State Administrative Hearings.

9.5.5.9.2. The Contractor or a representative of the Contractor will be expected to conduct follow-up evaluations to verify disputed findings as required, and to produce Summaries of Findings and other necessary reports at any point during the appeals process, from initial complaint to resolution to appeals hearings.

9.5.5.9.3. The Contractor or a representative of the Contractor will

be expected to provide testimony during appeals hearings (most frequently by telephone) as required.

9.5.5.10. Maintain a data tracking system, in a format agreed upon by the Contractor and the Department, which tracks prior authorization elements and deliverables described herein.

9.5.5.11. Maintain electronic and data interface capability necessary to exchange electronic reports with ALLIANT/GMCF, the Georgia Department of Community Health's Division of Medicaid and its rehabilitative services providers, and with the Department. The Contractor must ensure security and confidentiality of data and compliance with applicable federal and state laws (including HIPPA Privacy Rules, 45 CFR Parts 160 and 164).

9.5.5.12. Implement quality assurance and improvement activities that address, at a minimum, clinical training, and competency issues, including physician oversight, frequency and type of supervision, agency timeliness related to PASRR performance requirements, and peer review. The Contractor will describe the plan for continuous quality assurance and improvement in the performance of PASRR evaluations, including but not limited to the following:

9.5.5.12.1. Plan for agency staff clinical training and competency issues, including physician oversight, frequency, and type of supervision;

9.5.5.12.2. Agency timeliness related to PASRR performance requirements;

9.5.5.12.3. Peer review and documentation review procedures including frequency of reviews and sample size (Offeror shall specify activities conducted in peer review and documentation review procedures);

9.5.5.12.4. Partnering with the DBHDD as it conducts periodic quality audits of the contents and monitor timelines of evaluations.

9.5.5.12.5. If greater than 5% of the evaluations sampled are late, the Contractor will be expected to develop a plan to improve the timeliness of evaluations.

9.5.5.12.6. In the event of an audit or review of the state's PASRR program by CMS, the Contractor will make available to auditors all records of evaluations performed under the contract with the Department.

9.5.5.13. Produce reports required by the DBHDD, DCH, or the Centers for Medicaid and Medicare Services, including but not limited to formal quarterly reports detailing QA and improvement activities and the annual report. Reports may include (but are not limited to):

9.5.5.13.1. Number of referrals received through ALLIANT/GMCF

9.5.5.13.2. Number of assessments completed each quarter by category (MI, ID, or related condition)

9.5.5.13.3. Number of status change assessments

9.5.5.13.4. Number of rule-out's based on categorical information

9.5.5.13.5. Number of assessments approved, deferred, halted, or denied

9.5.5.13.6. Number of assessments referred for rehab services and

specialized services, respectively

9.5.5.13.7. Number of late assessments

9.5.5.13.8. Number of out of state referrals

9.5.5.13.9. Complaint log aggregated by total number of complaints, by types of issues, by issues resolved and issues not resolved

9.5.5.13.10. Using the DBHDD regional assignment of counties, total number of assessments completed within each county and within each region.

9.5.5.13.11. Number of record reviews conducted by Contractor for quality purposes and corresponding outcomes

9.5.5.13.12. Number and findings of peer review activity

9.5.5.13.13. Number and status of hearings.

9.5.5.14. Retain a complete hard copy of all evaluation documentation, including the summary of findings, for seven (7) years. The storage of Level II evaluations will be at the Contractor's expense. Upon termination of the contract for any reason, the Contractor will surrender, at the Department's request, all records maintained under the terms of the contract.

9.5.5.15. The Contractor will be responsible for developing and distributing written material that describes the processes and procedures to be followed in the PASRR program. These materials shall be distributed to all nursing facilities in the State at the beginning of the initial contract period. Periodic phone assistance shall be provided to nursing facility staff throughout the contract period, as needed.

10 Complaints and Grievance

10.1 Overview

10.1.1. Contractor must have a process to receive and monitor complaints about the Contractor's work.

10.1.2. Medicaid Beneficiaries are afforded certain rights as individuals in that program. One of the rights afforded to all Beneficiaries is the right to a Fair Hearing if there is a concern that Medicaid is not meeting the medical needs of the Individual. During the benefit application process, each applicant is provided a "Guide to Services" that explains the Fair Hearing processes. Providers are required to inform persons about their rights at the onset of services and periodically throughout the support duration.

This information is provided in a manner the Individual and family/caretakers can understand and is documented. The HCBS Waivers indicate who must inform HCBS Individuals about their rights upon enrollment in the Waiver. The information must include how the Individual may voice complaints or Grievances or make a request for a Fair Hearing. Individuals are informed that the filing of complaints is not a prerequisite or substitute for a Fair Hearing. The Individual/caretaker signs a statement that information about their rights was given to them and explained so they could understand it.

10.1.3. In its role, the Contractor may also receive other complaints or grievances which are related to the work of Providers or other work of the DBHDD. The Contractor will refer

these complaints to the DBHDD.

10.1.4. Specific to Grievances, the Contractor is expected to play a supportive role in Medicaid Grievance processes related to the functions of this contract. DCH is the responsible authority for all Medicaid Grievances.

10.2 General Requirements

10.2.1. The Contractor is required to develop and implement internal policies and practices that govern its response to complaints and grievances regarding Contractor activities and services.

10.2.2. The Contractor will collect and compile data regarding the types of complaints and grievances to which it responds, the response time in resolving them, and the final resolution.

10.2.3. The Contractor is required to report to DBHDD regarding the data collected in this section and any action taken to improve the service system.

10.3 Medicaid NOAA (Specific to Medicaid BH Services)

10.3.1. The Contractor is required to provide a written notice to Medicaid Recipients of any denials, suspensions, reductions, or terminations of Medicaid services issued by the Contractor and to include in this written notice the opportunity for the Recipient to request a Fair Hearing. (See Section 8. UM/UR).

10.3.2. The Contractor must permit the Recipient or his/her family/representative to make a formal request for a Fair Hearing at any time the Recipient finds that he/she: has been denied the service or Provider of their choice; whose services are denied, suspended, reduced, or terminated; or feels that other rules, regulations, or laws have not been followed in the determination of his/her eligibility or the delivery of his/her services.

10.3.3. If the person is unable to submit the Appeal in writing, he/she may request assistance from his/her respective RO, his/her local DFCS office, or the Contractor, and a staff person will be assigned to assist in submitting the request.

10.3.4. The Contractor will assist the DBHDD and/or DCH in any related Medicaid Fair Hearing by supporting, attending, representing, or otherwise informing the DBHDD/DCH process as requested.

10.4 Complaints and Grievance Process

10.4.1. There will be a Contractor grievance and complaints process defined by the

Contractor and approved by the DBHDD. The process will allow for complaints from Individuals served, Providers, and other stakeholders.

10.4.2. As directed by the DBHDD, the Contractor will refer appropriate complaints and grievances to the DBHDD and/or the DCH (e.g., complaints from an Individual related to his/her receipt of service, complaints regarding DBHDD and/or DCH policy).

10.4.3. Specific to the Contractor's work, the Contractor will collect, track, and compile data regarding the types of complaints to which it responds, the response time in resolving them, and the final resolution. This data will include general complaints as well as those which are related to the Contractor's direct services.

10.4.4. The Contractor is required to report to DBHDD regarding the data collected in this section, any action taken to improve the service system, and provide to the DBHDD any complaint, grievance or appeal-related reports in Appendix 26, Deliverables and Reports Matrix.

10.4.5. DBHDD Policy, Complaints and Grievances Regarding Community Services, 19-101 specifies that any Individual (or his guardian or parent of a minor Individual, if applicable) or his representative or any staff member may file a complaint alleging that the Individual's rights have been violated by staff members or persons under their control. DBHDD ensures that individuals, representatives, guardians, associations, agencies, contractors, sub-contractors, or those who seek to become involved with the delivery or receipt of services may file complaints and grievances.

10.4.6. A person who considers filing such a complaint is encouraged to resolve the matter informally by discussing it first with the staff members or other persons involved or with the program's consumers' rights staff as specified in the program's QM plan

10.4.7. The Individual is not required to use the procedures established by DBHDD Policy **19-101** in lieu of other available remedies, including the right to directly contact Constituent Services at the Office Public Relations at the DBHDD or to submit a written Complaint to the RO.

10.4.8. In order to ensure that such internal quality improvement investigations and monitoring activities are completed fully and in an in-depth manner, to encourage candid evaluations, and to ensure that adequate corrective action is taken in all cases, review actions taken and documentation made in furtherance of Policy 19-101 remain confidential.

10.4.9. Because of the direct service nature of the PASRR and GCAL lines of business

defined herein, the Contractor will appoint a Consumers' Rights Subcommittee to review the rights of the Individuals receiving services from these programs. The Consumers' Rights Subcommittee functions as a part of the Contractor's ongoing QM program, as described in the Contractor's QM Plan.

10.4.9.1. The complaint is filed with the Contractor's Consumers' Rights Subcommittee and it may be filed on a standardized form provided by the Contractor. If the Individual states the complaint orally, specific assistance is given by the Contractor in proceeding with the complaint and completing the form. Complaints may be made by telephone to customer service staff persons who complete the form. Staff members whose alleged conduct gave rise to the complaint may be informed of the complaint.

10.4.10. An IDD individual may also file a complaint or grievance with the IDD Human Rights Council (HRC). DBHDD Policy 02-1101 established the Human Rights Council as an advisory review body formed to ensure the protection of health and human rights of individuals with IDD. The Council reviews allegations of suspected individual rights violations; individual support plans in which individuals have been prescribed five or more psychotropic drugs; and all requests for participation of individuals receiving IDD services in experimental research to ensure adherence to the practiced of DBHDD.

10.4.11. The Contractor is required to report performance on all relevant PM's including timeliness standards for complaint resolution, as described in Appendix 18, PMs

11 Care Coordination, Discharge Planning, and Community Transitions[1]

11.1 Overview and General Requirements

11.1.1. The State is committed to increasing community resources and supports so that individuals can more easily transition from institutional settings into settings that promote recovery, independence, and community integration.

11.1.1.1. Care Coordination is provided by qualified service Providers.
11.1.1.2. The inpatient/institutional Provider is responsible for discharge planning in collaboration with community providers.
11.1.1.3. The DBHDD is responsible for participating and ensuring the quality of transition planning for Individuals in the settlement population.
11.1.1.4. Community Providers and Support Coordination Agencies are actively involved with discharge planning while Individuals are in institutions/inpatient facilities.
11.1.1.5 CPSs help bridge the transition.

11.1.2 Although Care Coordination, discharge planning, and community transitions are best addressed at the service delivery level as described above, the Contractor will support the current system in performance of these responsibilities.

[1] Care Coordination, discharge planning, and community transitions will be performed by UM staff, unless otherwise indicated

11.1.2.1 The Contractor will support the current system by identifying systemic barriers to successful Care Coordination, discharge planning, and community transitions.

11.1.2.2 The Contractor will improve the system's care coordination, discharge planning, and community transition activities by facilitating communication, sharing relevant information regarding system resources, providing meaningful data analytics and outcome measures, technical assistance, and training.

11.1.3 The specific Care Coordination activities the Contractor will perform will vary based on the population (i.e., BH, IDD, co-occurring) served. Not all functions will necessarily be performed for all populations.

11.2 Care Coordination Requirements

11.2.1. The Contractor will provide the following actions or interventions to support Care Coordination services delivered by Providers/care coordinators, which at a minimum, shall include:

11.2.1.1. Communication and collaboration with individuals' case managers, transition specialist, Support Coordinators, or other care coordinators connected to the Individual to facilitate resolution of complex or difficult care situations.

11.2.1.2. Suggest clinically indicated services or service alternatives when appropriate during UM/UR.

11.2.1.3. In collaboration with community-based Providers and hospitals, enhance Care Coordination by providing information, as requested, about Individuals' recent and historical service utilization activity (with appropriate permissions).

11.2.1.4. The Contractor will coordinate with inpatient facilities and other care coordinators involved with Individuals when discharge planning and transition will include services administered by DBHDD.

11.2.1.5. When applicable, record in the client database or update the Individual's external Care Coordination agent (e.g., ABD care coordinator, CMO, SC, Care Manager or CME) information and specialty care provider information to make sure it is current and accurate.

11.2.1.6. As needed, facilitate communication between DCH-contracted care coordinators and CMOs (as the limits of confidentiality permit) to promote optimal outcomes and reduce risks, duplication of services, or errors.

11.2.1.7. The Contractor will receive a monthly download and provide monthly analysis of Medicaid claims for outpatient, inpatient, emergency services, medical supplies and equipment, physician, and pharmacy claims data for Recipients of BH and IDD services. At a minimum, the Contractor will:

11.2.1.7.1. Analyze the data to identify individuals in need of more active Care Coordination or access to additional supports or services to reduce unnecessary emergency room and inpatient utilization.

11.2.1.7.2. The Contractor will collaborate with other Care Coordination Entities available to assist the Individual, including support coordinators for people with IDD, to

discuss findings and promote enhanced coordination.

11.2.1.7.3. Review the data to monitor prescription medication use.

11.2.1.7.4. Identify opportunities for reduction of service duplication and/or overutilization.

11.2.1.7.5 Develop a report that summarizes the review process, results, and recommendations.

11.2.1.8. Assist the DBHDD and Providers to locate, contact, and reconnect individuals to care when there are unexpected interruptions in care (e.g., provider closures, terminations, disasters).

11.2.1.9. Provide a mechanism, in conjunction with the UM/UR Program and in accordance with DBHDD and/or DCH-approved protocols depending on funding source, for offering some Individuals a choice of at least two (2) Providers (when available). These referrals may be based on Individual characteristics such as age, county/city of residence and/or may be based on utilization data that indicates an Individual would benefit from more intensive engagement and/or Care Coordination at the Provider level (e.g., utilization of high-cost inpatient and crisis services; seeking services, diagnoses, and/or prescriptions from multiple providers concurrently or in succession).

11.2.1.10. The Contractor will educate and assist Providers regarding proper procedures for making appropriate referrals for physical health consultation and treatment.

11.2.1.11. The Contractor will develop and implement with approval from DBHDD, procedures that govern and monitor confidentiality, implementation of transition activities, monitoring of coordination activities, and clinical record reviews.

11.3 Discharge and Transition Planning Requirements

To support discharge and transition planning activities for Individuals, the Contractor will provide the following:

11.3.1. During continued stay reviews with Intensive BH Services Providers, and as requested, the Contractor will:

11.3.1.1. Provide information regarding an Individual's history with successful/unsuccessful community placement.

11.3.1.2. Recommend available community-based services to facilitate successful community transition and integration.

11.3.1.3. Consider recommending customized Care Coordination options such as a CME, ACT, or ICM as a supporting mechanism when needed.

11.3.2. Establish communication protocols with jails and prison regarding accessing needed BH and IDD services for Individuals being discharged.

11.3.2.1. Recommend available community-based services to facilitate successful community transition and integration, based on

Individual's service history.

11.3.3. If an HCBS Individual is identified through UR processes as having under-utilization of Authorized Services or patterns of high utilization of crisis services, emergency room, and institutional or inpatient care along with low utilization of community supports, Contractor will work with DBHDD to review the POC and/or ISP and recommend community-based alternatives to facilitate successful transition and community reintegration.

11.4 The Contractor will provide education and training to inpatient, hospital emergency department, institutional, and Intensive BH and IDD Services Providers to promote effective discharge planning and appropriate use of community resources.

11.5 The Contractor will develop and distribute written educational material for the general public, law enforcement, and for medical and other providers to increase awareness of DBHDD services, eligibility for services, point(s) of entry for services and opportunities for collaboration in the overall health and wellbeing of Individuals who receive or require BH and IDD services.

11.6 The Contractor will initiate and participate in regularly scheduled meetings with inpatient, hospital emergency departments, institutional and Intensive BH Services Providers, Ros, community service Providers, and other referral services to discuss barriers to effective Care Coordination, discharge, and transition planning.

11.7 Reporting

11.7.1. As part of UM/UR reporting, the Contractor will collect, analyze, and report on data regarding barriers to successful Care Coordination, discharge, and transition planning to make recommendations regarding possible system improvements. Specifically, the Contractor will:

11.7.1.1. Monitor capacity and utilization of residential programs and other slot-based services (e.g., State-funded PRTF, supported employment, ready for work, Community Residential Rehabilitation services paid on a per diem basis, DBHDD-funded and State-operated Community Residential Services, etc.) to assist Providers in identifying programs that have capacity to meet the needs of Individuals transitioning to or being diverted from higher LOCs.

11.7.1.2. Identify systemic strengths and gaps in services, supports, and resources that could promote successful community transition.

11.7.1.3. Report provider training and meeting activities to address barriers.

12. Quality Management

12.1 General Requirements

12.1.1. The Contractor will develop and implement an effective QM program that supports

DBHDD's QM Plan. ("QM" is inclusive of QM, quality improvement, and quality assurance activities).

12.1.2. The Contractor will develop and implement an effective internal QM program.

12.1.3. The Contractor will comply with all applicable DBHDD and DCH QM requirements.

12.1.3.1. These requirements may change over time as DBHDD and DCH make system changes in response to QM findings, audits, or stakeholder feedback. DBHDD's current QM plan and activities are provided in Appendix 29, DBHDD QM Plan.

12.1.4. The Contractor will participate in DBHDD QM planning and activities to help improve the functioning of the overall BH and IDD service delivery systems and outcomes.

12.2 Contractor's QM Program
The Contractor will:

12.2.1. Establish an internal QM Program plan, policies, and procedures that are consistent with DBHDD philosophy and complementary to the DBHDD QM plan.

12.2.2. The QM Program will integrate QM processes across all areas of the Contractor's organization (related to the functions described within this document and the Contractor's response) with accountability to the Contractor's CEO.

12.2.3. At a minimum, the Contractor's QM Program will be documented in a QM plan, program description, and internal policy and procedure manuals.

12.2.4. The QM Program will distinguish the Contractor's internal QM Program from the QM activities (see below) the Contractor will provide in support of DBHDD's QM plan.

12.2.5. The QM Program will address the differing QM requirements for each population served (e.g., Medicaid BH, State-funded BH, HCBS (e.g., IDD) and State-funded IDD.

12.2.6. By no later than January 31st of each FY, the Contractor will submit to DBHDD for approval a revised and updated QM plan and program description.

12.2.7. The Contractor's QM plan will include the following components:

12.2.7.1. A sufficient number of qualified and trained MH, AD, and IDD staff members to competently implement all QM Program requirements on a timely basis.

12.2.7.2. Processes to assess, plan, implement, measure, evaluate, monitor, and

report on QM activities directed toward improving the services provided to Individuals, family members, and community Providers including, but not limited to call center activities; dispatch of MCTs; administration of appeals, complaints, and grievances; Claims payment; etc.

12.2.7.3. Processes to assess, plan, implement, measure, evaluate, monitor, and report on QM activities directed toward improving the performance of community Providers. These activities will include, but are not limited to UM/UR; care coordination; Provider audits (including auditor reliability checks), technical assistance and training; and data management, exchange, and reporting.

12.2.7.4. Implementation of an industry-recognized model for continuous improvement (e.g., Six Sigma; Plan, Do, Study, Act; Design, Measure, Analyze, Improve, and Control).

12.2.7.5. Processes to assess, evaluate, monitor, report on, and ensure integrity of data used in the QM Program, including data produced by the Contractor, and data received, managed, and utilized by the Contractor from other sources (e.g., providers, GAMMIS, and DBHDD).

12.2.7.6. The Contractor will implement automated processes to ensure data received from other sources is accurate, timely, and complete.

12.2.8. The Contractor will maintain an active QM committee, which will include Individual, family member, advocate, Provider, and quality improvement council representatives as designated by DBHDD.

12.2.8.1. The QM committee is responsible for carrying out the planned activities of the QM Program and is accountable to DBHDD for the effectiveness of the QM Program.

12.2.8.2. The Contractor will lead regular QM committee meetings and maintain records documenting attendance, committee findings, recommendations, and actions.

12.2.8.3. The Contractor will present reports on its QM activities to the DBHDD Executive Quality Council semi-annually.

12.2.8.4. The Contractor will designate the chief medical officer) as QM committee co-chairs having responsibility for the QM Program.

12.2.8.5. The chief medical officer will have substantial involvement in QM Program functions and serve as the chairpersons for the Contractor's QM and continuous care improvement committees. The MD will also serve as the chairperson for the UM/UR committee.

12.2.8.6. The Contractor will review complaints regarding the rights of Individuals receiving services from the Contractor's programs, either directly or indirectly. (See Section 10, Complaints and Grievances for more information.)

12.3 Quality Management Activities in Support of the DBHDD QM Plan

12.3.1. In collaboration with DBHDD, the Contractor will develop a QM plan, program description, and internal policy and procedures that support DBHDD's QM plane.

12.3.2. The Contractor will document the QM plan and activities that support DBHDD's QM plan.

12.3.2.1. These activities will be distinguished from the Contractor's internal QM Program.

12.3.2.2. The QM activities will address differing QM requirements for each population served (e.g., Medicaid BH, State-funded BH, HCBS (e.g., IDD) and State-funded IDD).

12.3.3. The initial QM plan and program description that supports DBHDD QM activities will be submitted to DBHDD for approval three (3) months prior to the Go Live Date.

12.3.4. By no later than January 31st of each year, the Contractor will submit to DBHDD for approval a revised and updated QM plan program description that supports DBHDD QM plan and activities.

12.3.5. The QM plan will address the following components, at a minimum:

12.3.5.1. Identification of systemic quality concerns or issues, strategies for improvement, and correction recommendations.

12.3.5.2. Education of stakeholders about QM activities and national trends, emerging best practices, or recommendations regarding QM (e.g., Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Quality Framework for BH; CMS Quality Framework).

12.3.5.3. Solicitation of feedback from stakeholders, including individuals, family members/caretakers, Providers, Advisory and QI Councils, and Advocacy Agencies.

12.3.5.4. Aggregating and analyzing information from DBHDD, Providers' and Contractor's QM activities.

12.3.5.5. Monitoring, aggregating, and presenting information regarding Providers' performance relative to applicable practice guidelines, EBPs, appointment access standards, POCs, and ISPs in a Provider Performance Profile format that encourages self-correction and includes, but is not limited to:

12.3.5.5.1. Provider utilization information (see Section 8. UM/UR for more information).

12.3.5.5.2. Individual outcomes.

12.3.5.5.3. Complaints.

12.3.5.5.4. Satisfaction survey results.

12.3.5.5.5. Relevant information from Provider audit reports, quality of service reviews, PRRs, corrective action plans (CAPs), quality improvement plans, and QEPRs.

12.3.5.5.6. Information collected from other sources (e.g., DBHDD, NCIS, provider specific performance data, etc.).

12.3.5.5.7. Compliance with HCBS requirements and QAs.
12.3.5.5.8. Compliance with PMs.
12.3.5.5.9. Prequalification, verification, and Continued Qualification Requirements data.
12.3.5.5.10. Other indicators as requested, (e.g., quality council recommendations regarding what to measure).

12.4 Performance Measurement for HCBS and IDD State-Funded Services

12.4.1. General Requirements:

By implementing the QM plan, which incorporates the values and principles found in the CMS Quality Framework for Home and Community-Based Service (http://www.cms.hhs.gov/HCBS/04), the Contractor assumes the primary role in monitoring the quality of care for the State's HCBS Programs, which currently include the NOW, the COMP, and other waivers as they come online.

12.4.2. HCBS quality of care monitoring will focus on seven (7) desired outcomes:

12.4.2.1. Individuals have access to HCBS in their communities.
12.4.2.2. Services and supports are planned and effectively implemented in accordance with each Individual's unique needs, expressed preferences, and decisions concerning his/her life in the community.
12.4.2.3. There are sufficient HCBS Providers that possess and demonstrate the capability to effectively serve Individuals.
12.4.2.4. Individuals are safe and secure in their homes and communities, taking into account their informed and expressed choices.
12.4.2.5. Individuals receive support to exercise their rights and in accepting personal responsibilities.
12.4.2.6. Individuals are satisfied with their services and achieve desired outcomes.
12.4.2.7. The system supports Individuals efficiently and effectively, and constantly strives to improve quality.

12.4.3. Consistent with Medicare, Medicaid, HCBS, State, and the existing DBHDD QM system, the Contractor will develop processes and internal policy and procedure to effectively implement the review of the HCBS assurances and sub-assurances as defined in 42 CFR §441.301 and §441.302 and the approved HCBS Authorities; currently outlined in Appendices 2 and 3 of the IDD Waivers and authorities (Appendices 2 and 3 (COMP and NOW Waivers)) or as revised as a result of future evaluations or changing CMS requirements:

12.4.3.1. The Contractor will incorporate the quality improvement strategy for the HCBS Authorities into the Contractor's quality plan that supports DBHDD's QM program.

12.4.3.2. The State has made the assurances and sub-assurances listed in Appendices 2, 3 and 13 to the federal government through the approved HCBS Authorities. As part of the assurances and sub-assurances, DBHDD has agreed to monitor the HCBS PMs and report on those

measures to CMS in the following manner:

12.4.3.2.1. On a continuous basis, with reports due quarterly, DBHDD will review the Contractor's documentation of remediation of identified issues resulting from LOC assurance monitoring.

12.4.3.2.2. The Contractor will immediately notify DBHDD of any situation in which the health and safety of an Individual is jeopardized.

12.4.3.3. The Contractor will create processes to support DBHDD QM in measuring and improving performance of state-funded and HCBS services and which meet the HCBS assurances that are set forth in 42 CFR §441.301 and §441.302 and the approved CMS authorities. The Contractor will develop, maintain, and implement a QM System Procedure Manual by the Go Live Date that addresses at a minimum the following:

12.4.3.3.1. The values and principles of person-centered practice.

12.4.3.3.2. Risk assessment, planning, and prevention.

12.4.3.3.3. Provider monitoring, including Support Coordination Providers.

12.4.3.3.4. The role of Case Management/Support Coordination in QM.

12.4.3.3.5. Incident management systems.

12.4.3.3.6. Health screening tool similar to the Health Risk Screening Tool (HRST) currently utilized across the State.

12.4.3.3.7. How Individual feedback is integrated into the QM plan, including data from the National Core Indicators Surveys (NCIS).

12.4.3.3.8. Using data for QM consistent with the approved Authorities.

12.4.3.3.9. Monitoring of specific PMs and outcome measures approved by CMS in the HCBS Authorities.

12.4.3.3.10. Mechanisms to measure and report on the HCBS PMs listed in the Authorities.

12.4.3.3.11. Implementation of approved QM Programs.

12.4.3.3.12. Dissemination of the procedures manual.

12.4.3.3.13. For IDD Waiver Individuals, the monitoring of the use of Supports Intensity Scale (SIS) (http://www.siswebsite.org) for Waiver eligibility and in the development and reviewing of ISPs.

12.4.3.3.14. Inter-rater reliability of review staff, not limited to the review of LOC, POC, and ISPs during HCBS quality reviews.

12.4.3.3.15. For IDD Waiver Individuals, using a sampling methodology approved by DBHDD, review a sample of Providers selected QEPRs (see description below), including, PLA, Support Coordination, and community service Providers.

12.4.3.3.16. Collection and analysis of data to aid in the development of a Provider quality reporting system, including the development of Provider performance profiles.

12.4.3.3.17. Development of specific PM and outcome measures based on findings from QAs (e.g., face-to-face interviews, Provider reviews) and input from DBHDD.

12.4.3.3.18. Analysis and reporting on success or failure to meet PMs and outcome measures, suggesting strategies to improve quality.

12.4.3.3.19. Collaborative education and training for Individuals, their families/caretakers, Providers, Support Coordination agencies and State staff based on the findings of reviews.

12.4.3.3.20. Schedule for monthly, quarterly, and annual QM reports.

12.4.3.4. The Contractor will maintain a training manual and curriculum, for reviewers conducting QEPRs. The training manual will specify the populations and authorities to which each process is applicable (e.g., IDD waiver and state-funded population population). Review the adequacy of services and supports for achievement of an Individual's individually defined outcomes during the previous year. This manual will include:

12.4.3.4.1. Tasks related to use of the NCI Interview instrument, ISP QA Checklist, SC Record Review, Administrative Record Reviews (e.g., review of policy and procedure, staff qualifications, and training), Staff/Provider interviews, onsite observations of residential or day programs (not scored), and measures of family satisfaction with the NCI Family/Guardian Survey or the Adult Family Survey, FUTAC and gathering of information on the NCI Consumer Survey, PRR, Staff/Provider interview, and onsite observations.

12.4.3.4.2. Interview elements (e.g., notification of interview schedules, sample selection, review instruments, review protocols, and dissemination of findings).

12.4.3.4.3. Language that confirms the interviews are voluntary for Individuals.

12.4.3.4.4. A requirement that copies of the manual are delivered to all audited Providers, without charge, at least ten (10) days prior to the commencement of the scheduled review.

12.4.3.4.5. Explanation that the cost of reproducing records is the responsibility of the service Provider.

12.4.3.4.6. A requirement that information requested from service Providers will be limited to that which is necessary to conduct a thorough review.

12.4.3.4.7. Identify how needed information from Providers will be obtained.

12.4.3.4.8. Standardized Provider information requests.

12.4.3.4.9. Audit procedures to determine if Provider qualifications are

met.

12.4.3.4.10. Audit procedures to determine if standards from Provider manuals are met.

12.4.3.4.11. NCIS; Individual Interview Instrument

12.4.3.2.11.1 These may be part of the QEPR, or be outside the QEPR to ensure adequate sampling.

12.4.3.5. The Contractor will provide training and technical assistance to DBHDD-contracted Support Coordination agencies (currently there are four Support Coordination agencies. The Contractor will:

12.4.3.5.1. Assess the training needs of the SCs based on the findings of the QEPRs.

12.4.3.5.2. Conduct training to address issues discovered during the, PRRs, and QEPRs on a quarterly basis.

12.4.3.5.3. Conduct eight (8) of training per FY.

12.4.3.5.4. DBHDD must pre-approve training topics, locations, dates, and training materials.

12.4.3.5.5. Evaluations of each training session shall be completed and appropriate changes made to the training sessions based on evaluation findings.

12.4.4. Quality Assurance Discovery Processes and Procedures for PRRs

Annually, using a sampling methodology approved by DBHDD, the Contractor will review for a statistically significant number of Individuals with IDD receiving HCBS and State- funded services:

12.4.4.1. Provider Record Reviews (PRR)

A PRR includes, but is not limited to the following:

12.4.4.1.1. A Medicaid claims analysis that validates all authorized and paid services were received;

12.4.4.1.2. A review of other records, including incident and critical incident records crisis system access; and

12.4.4.1.3. A review of data regarding service and support plans, monitoring reports, and LOC data.

12.4.4.1.4. Current health status.

12.4.4.1.5. Behavioral status, including diagnosis.

12.4.4.1.6. Medicaid services received, including Waiver services.

12.4.4.1.7. ISP QA Checklist results.

12.4.4.1.8. Record review results.

12.4.4.9.8. At a minimum, the following determinations:

12.4.4.9.8.1. Was the ISP completed on a timely basis?

12.4.4.9.8.2. Was the ISP based on the identified needs of the Individual?

12.4.4.9.8.3. Were the Individual's preferences taken into consideration in development of the ISP?

12.4.4.9.8.4. Were all Authorized Services received?

12.4.4.9.8.5. Were services delivered consistent with the

12.4.4.9.8.6. Were additional services and modifications to the ISP needed once the Individual began receiving services?

12.4.4.9.8.7. Does the ISP reflect progress?

12.4.4.9.8.8. Appropriate action has been taken to address

any evidence of mistreatment, abuse, neglect, or exploitation; and

12.4.4.9.8.9. Other findings and opportunities for improvement in services and supports provided to the Individual.

12.4.5. The Contractor will conduct QEPRs. The QEPRs:

12.4.5.1. Evaluate the effectiveness of a Provider's supports and services, organizational systems, records, staff training, qualifications, and compliance with DBHDD's policies and procedures.

12.4.5.2. Apply to all IDD service providers including, but not limited to: State-funded and HCBS Providers; Support Coordination; Planning List Administration; and State Services Coordination Providers

12.4.5.3. Are conducted onsite for a statistically valid sample of HCBS providers and a statistically valid sample of State-funded IDD Providers.

12.4.5.3.1. Currently, there are three hundred and eighty-one (381) IDD Waiver-funded service Providers, eighty-six (86) State-funded service Providers, and four (4) Support Coordination agencies in Georgia.

12.4.5.3.2. Those selected for QEPR will be based on a statistically valid, random sample. Please see the Human Services Research Institute (HRSI) website (HRSI.org) for further details about survey tools and methods.

12.4.5.4. All NOW, COMP, and State-funded IDD Providers will be reviewed at least once every four (4) years.

12.4.6. The QEPR includes, but is not limited to the following components:

12.4.6.1. A Provider Record Review, which includes, but is not limited to the following:

12.4.6.1.1. A Medicaid claims analysis that validates all authorized and paid services were received;

12.4.6.1.2. A review of other records, including incident and critical incident records; and

12.4.6.1.3. A review of data from DBHDD's web-based system (e.g., Currently Columbus Information System).

12.4.6.1.4. An administrative record review (e.g., provider policy and procedure, staffing plans, training records).

12.4.6.1.5. Individual Interview Instrument

12.4.6.1.6. ISP QA Checklist.

12.4.6.1.8. Staff Provider interviews.

12.4.6.1.9. Onsite observation of the physical environment and service delivery sites.

12.4.6.1.10. Interviews with support coordinators.

12.4.6.1.11. Review and scoring of SC monitoring activities.

12.4.7. QEPR Reports

For each QEPR, the Contractor will prepare a preliminary summary of review findings and discuss these in an exit interview with the Provider.

12.4.7.1. The QEPR reports will record strengths and deficiencies of the Provider's service delivery systems, with recommendations to improve Provider practice, will be identified.

12.4.7.2. For each Provider reviewed, the Contractor will submit via email and web-based portal, a report of the QEPR findings to DBHDD no later than thirty (30) calendar days from the date of the conclusion of the onsite review.

12.4.7.3. The QEPR report shall be provided to the Provider.

12.4.7.4. The QEPR report will address at a minimum:

12.4.7.4.1. Summary of strengths (including best practices).

12.4.7.4.2. Summary of deficiencies.

12.4.7.4.3. Recommendations for practice improvement.

12.4.7.4.4. Any facts indicating possible Fraud or Abuse (which must be acted on consistent with Section 3.3. Compliance of this Contract).

12.4.7.4.5. Recommendations for recoupment of State funds by DBHDD.

12.4.7.4.6. Recommendations for QUTAC.

12.4.7.5. QUTAC is a consultative technical assistance process conducted for any Provider who, through previous onsite monitoring, failed to demonstrate compliance with standards or exhibited significant quality of care issues. QUTACs may be conducted either on-site, via phone, or via web depending on the type of technical assistance that is required.

12.4.7.5.1. QUTAC is conducted within ninety (90) days of the completion of a QEPR, or at any time for the following reasons:

12.4.7.5.1.1. Consecutive or multiple Support Coordination monitoring reports scored at a three (3) or four (4) for the same reason on a scale of 1–4, with 1 being the best;

12.4.7.5.1.2. Consecutive or multiple Critical incidents;

12.4.7.5.1.3. Complaints or Grievances received at the regional or State level;

12.4.7.5.1.4. Health/safety or rights issues;

12.4.7.5.1.5. Requests for technical assistance from Providers who have participated in the QEPR or QUTAC process; or

12.4.7.5.1.6. New providers who have not yet been certified.

12.4.7.5.2. For informational purposes, approximately 350 QUTACs are currently completed each year.

12.4.7.6. Once approved by DBHDD, the Contractor will use the QEPR reports for the following:

12.4.7.6.1. To provide technical assistance to the Providers and DBHDD.

12.4.7.6.2. To aid in the development of a Provider quality reporting system and Provider performance profile.

12.5 Performance Measurement for Medicaid (non-HCBS) and State-Funded Services

12.5.1. Approved Quality Indicators (Qis), KPIs and PMs

The Contractor will evaluate the State's non-HCBS service delivery system by measuring performance on approved Qis/KPIs related to DBHDD's Community BH and IDD QM plans. These Qis/KPIs will address, but are not limited to:

12.5.1.1. Outcome measurement for the delivery system as a whole (i.e., attainment of clinical and functional outcomes by service line and system goals (e.g., institutionalization, employment, housing stability, reduction in criminal justice involvement, attainment of needed social benefits (e.g., Medicare, food stamps), receiving appropriate wellness and preventive care, etc.).

12.5.1.2. Call center performance.

12.5.1.3. MCT effectiveness in assisting in safely resolving crisis situations with Individuals in the community and diverting them from unnecessary, higher LOC.

12.5.1.4. Speed of response to crisis calls and by mobile crisis and ACT teams for Individuals enrolled and not enrolled in DBHDD services.

12.5.1.5. Timeliness of service access to all LOC.

12.5.1.6. Service utilization and cost for each LOC, identifying trends, outliers, and length of stay, as appropriate.

12.5.1.7. Ambulatory follow-up appointment attendance at seven (7) and thirty (30) days post-discharge from residential and acute care.

12.5.1.8. Readmissions to inpatient facilities, institutions, and crisis stabilization units

12.5.1.9. Repeated calls, texts, or chats to crisis line and/or repeated mobile crisis dispatches.

12.5.1.10. Racial and ethnic disparities (e.g., under-utilization of services by particular racial/ethnic groups).

12.5.1.11. Network adequacy.

12.5.1.12. Individual (consumer) satisfaction

12.5.1.13. National Core Indicator Survey.

12.5.1.14. The National Outcome Measures (NOMS) and Treatment Episode Data Set (TEDS) required for SAMHSA block grants and any federal discretionary grants in which DBHDD may participate.

12.6 Non-HCBS

12.6.1. DBHDD and the Contractor, separately and together, will conduct onsite compliance, quality, and technical assistance audits for BH and DD providers.

12.6.2. The purpose of these audits is to complete an objective review of Provider practices and outcomes. In addition, the audit will provide a forum for targeted technical assistance based on findings (Note: State hospitals and contracted hospitals will not be audited onsite.)

12.6.3. The Contractor's audits will provide information needed for the annual quality reviews of providers as specified in Section IV.A of the ADA settlement agreement (see Appendix 8). For a sample of providers annually, this information will include reviews of treatment records and interviews with individuals, residents and staff and may include on-site review of incident/injury data.

12.6.4. DBHDD will continue to conduct the following audits:

12.6.4.1. IDD Provider Performance Reviews.
12.6.4.2. Substance abuse prevention services audits.
12.6.4.3. Adult substance abuse services audits.
12.6.4.4. Adolescent substance abuse recovery support/block grant funded Provider audits.
12.6.4.5. Ready for work services audits.
12.6.4.6. ACT and supported employment fidelity review audits.

12.6.5. Audit frequency is determined by DBHDD based on previous performance, types of services provided, utilization, volume, data trends, complaints.

12.6.6. Audits will be conducted by sufficient number of professionals who are licensed and/or certified/qualified clinicians (i.e., CAC II or equivalent, IDD professional/DDP) to ensure the validity, reliability, and achievement of the desired outcomes of the audits, as well as consideration of minimizing potential disruption to providers.

12.6.7. Audit focus will include Provider compliance with DBHDD and DCH's Provider manuals.

12.6.8. Audits will be conducted using standard tools approved by the DBHDD.

12.6.9. Audits will include agency program documentation reviews, staff interviews, Individual interviews, onsite observation of the physical environment and service delivery, treatment record, and personnel and training record reviews.

12.6.10. Record reviews will be based upon a random sample of records sufficient to discern practice patterns.

12.6.11. Record reviews may target a subset of the population based on agreed upon selection criteria, which may include:

a. High risk populations.
b. Individuals with recent negative outcomes or transitions from higher LOC.
c. High intensity BH and IDD services.
d. Individuals with high utilization of certain services (i.e., crisis system).
e. Individuals who have had a recent critical incident.

f. ADA target population.

12.6.12. Record reviews will address the quality of assessments, ISPs, service provision, documentation, billing and Claims, and continuity between these processes.

12.6.13. Billing and Claims-related reviews will include a Medicaid Claims analysis that validates all authorized and paid services were received, and/or State-funded Claims analysis that validates all authorized and paid services were received.

12.6.14. Other records to be reviewed include, but are not limited to:

a. Incident and critical incident records.
b. An administrative record review of Provider staffing, training, policy, and procedure.
c. Other records as indicated, consistent with the purpose of the audit.

12.6.15. Audit reports will include the following:

12.6.15.1. An overall score as well as sub-scores on the elements of the audit.
12.6.15.2. Summary of strengths (including best practices).
12.6.15.3. Summary of deficiencies.
12.6.15.4. Recommendations for practice improvement may address:
12.6.15.4.1. Access, fidelity to practice guidelines and EBP, compliance, coordination, and continuity among treatment and supports (e.g., housing, employment), data integrity, documentation practices.
12.6.15.4.2. Any facts indicating possible Fraud or Abuse (which must be acted on consistent with Section 3.3. Compliance of this Contract).
12.6.15.4.3. Recommendations to DBHDD for recoupment of Medicaid and/or State-funds.
12.6.15.4.4. Recommendations for follow up.
12.6.15.4.5. Audit reports will be structured such that DBHDD can parse performance by region, Provider type, and services.
12.6.15.4.6. A summary of audit results will be documented and published on the public website in the form of a Provider performance profile within thirty (30) calendar days of the audit end date.

12.6.16. The Contractor will make resources available to conduct ad hoc (non-routine) audits as requested by the DBHDD, approximately ten to fifteen (10–15) per year.

12.6.17. The Contractor will implement announced and unannounced audits, depending on the purpose of the review.

12.6.18. The Contractor will provide an appeal mechanism for Providers who disagree with findings, which may include review by a committee comprised of Contractor, Provider peers, and DBHDD representatives.

12.6.19. See appendix 24, Current BH ERO Audit Tool Link for information regarding current practice.

12.7. Reports to External Agencies

12.7.1. The Contractor will collect, analyze, and report on data required by federal and State agencies or other oversight organizations as required.

12.7.2. The Contractor will support DBHDD by collecting the necessary data and preparing tables to meet federal requirements for the Uniform Reporting System (URS). See Appendix 35, Appendix 36 or http://www.nri-inc.org/projects/SDICC/Forms/13URSInstructions.pdf for requirements.

12.7.3. The Contractor will meet federal requirements for the Drug & Alcohol Information System reporting. See Appendix 38 and Appendix 39; or http://wwwdasis.samhsa.gov/dasis2/index.html for requirements. The Contractor will:

12.7.3.1. Capture TEDS data to meet SAMHSA requirements.
12.7.3.2. Create the required cross-walk from Contractor's information system codes to the TEDS values, to be approved by DHBDD for submission to SAMHSA or designated vendor.
12.7.3.3. Produce and submit the necessary data files to SAMHSA or designated vendor as required.
12.7.3.4. Maintain the required Provider information for the Inventory of Behavioral Health Service Providers.

12.7.4. The Contractor will support federal requirements for MH Client Level Data Reporting (CLDR). See Appendix 37; http://www.nri-inc.org/projects/SDICC/Forms/CLD2013Manual.pdf for requirements. The Contractor will:

12.7.4.1. Upload State hospital psychiatric admissions for inclusion in the report.
12.7.4.2. Create the required crosswalk from the Contractor's information system codes to the CLDR values to be approved by DBHDD for submission to SAMHSA or designated vendor.
12.7.4.3. Produce and submit the necessary data files to SAMHSA or designated vendor as required.

12.8. Provider Performance Profiles

12.8.1. The Contractor will collect, analyze, and organize descriptive and performance-based data on Georgia's Providers in a web-based system that is accessible to State staff, individuals and their families/caretakers, and other stakeholders wanting to learn more about a Provider.

12.8.2. The Contractor will analyze and evaluate provider-specific performance data gathered from various data sets including, but not limited to: utilization data, approved Qis/KPIs, PMs, QEPRs, FUTAC, other audits to develop Provider Performance Profiles.

12.8.3. The Contractor will provide an online data entry or upload of DBHDD-provided and/or Providers' self-reported performance indicators as identified by DBHDD.

12.8.3.1. Provider Performance Profiles will be available in multiple formats (e.g., hard copy reports, web-based data reports).
12.8.3.2. Provider Performance Profile elements will be different depending on the audience for which they are intended (e.g., public use, QM use, State use).
12.8.3.3. Provider Performance Profiles designed for public use will use language that is fifth (5^{th}) grade reading level or lower.
12.8.3.4. Provider Performance Profiles that include outcome data must be accompanied by an explanation of the meaning of such data.

12.9. Provider Training

12.9.1. Within sixty (60) days prior to the Go Live Date, the Contractor will develop and submit an initial Training Plan to DBHDD for approval that describes initial and ongoing Provider training; the Training Plan will be updated annually thereafter.

12.9.2. The Contractor will develop, provide, and revise Provider trainings through in-person, internet, video or audio conferencing, online seminars, and other mechanisms as appropriate.

12.9.3. The Contractor is responsible for the development, delivery, and cost of all training, training materials, and promotional materials.

12.9.4. DBHDD must pre-approve training topics, locations, dates, and training materials.

12.9.5. Training may be conducted in collaboration with the regional and State offices.

12.9.6. The Training Plan will require attendance documentation and evaluation for each training offered.

12.9.7. The Training Plan will include, but is not limited to the following topics:

12.9.7.1. Provider contract requirements.
12.9.7.2. Provider manual and website overview to promote compliance with Provider performance standards.

12.9.7.3. GCAL Dashboard training.
12.9.7.4. Data and claims submission requirements.
12.9.7.5. Procedures related to interactions with the Contractor.
12.9.7.6. Implications for Provider operations due to changes in State and federal laws, regulations, policies, or procedures are being implemented.
12.9.7.7. Provider performance profile methodology and interpretation.
12.9.7.8. Practice guidelines, EBPs, and national practice trends.
12.9.7.9. Billing and Claims practices.
12.9.7.10. Documentation.
12.9.7.11. Other training topics based on need.

12.9.8. The Contractor will submit annual Provider training reports that summarize Contractor performance relative to the Training Plan.

12.9.9. The Contractor will identify Provider training needs based on PRR, QEPR, FUTAC, audits and reviews, Complaints, Provider Performance Profiles, self-identified training needs, and Stakeholder input and recommend training strategies to DBHDD.

12.9.10. The Contractor will collaborate with Georgia Mental Health Consumer Network, Georgia Council on Substance Abuse, and other peer certification bodies to train peers on pertinent information such as documentation practices and ISP development.

12.9.11. In compliance with HCBS requirements, the Contractor will conduct training for IDD Providers.

12.9.11.1. The Contractor will conduct a minimum of eight (8) trainings each year. In addition, provisions will be made for at least two (2) HCBS trainings to be conducted in each region annually.

12.9.12. The Contractor will conduct training for BH Providers.
12.9.12.1. The Contractor will conduct a minimum of eight (8) trainings per year. Provisions will be made for at least two (2) trainings to be conducted in each region annually.

12.10. Staff Training

The Contractor will:

12.10.1. Within one month after the Contract Award date, the Contractor will develop and implement a staff Training Plan that describes initial and ongoing training of the Contractor's personnel and subcontractors.

12.10.2. The staff Training Plan will incorporate the plan for training staff during implementation as well as ongoing training activities.

12.10.2.1. The Contractor will submit the implementation staff Training Plan to DBHDD for preapproval as part of the implementation plan.

12.10.3. Have a mechanism for DBHDD input into staff training curricula.

12.10.4. Provide required initial orientation and ongoing training to all full and part-time personnel and to all subcontractors.

12.10.5. Ensure that all formal training includes a training curricula, documentation of attendance, competency testing, and a remediation plan for Individuals who do not pass competency tests.

12.10.6. Provide training (in-person, online, webcasts, etc.) coaching, modeling, technical assistance, supervision, and observation to assure that all personnel and subcontractors have the knowledge and skills necessary to perform assigned functions required by this Contract. As indicated, all training will specifically address:

12.10.6.1. IDD requirements.
12.10.6.2. BH requirements.
12.10.6.3. HCBS requirements.
12.10.6.4. Medicaid requirements.
12.10.6.5. State requirements.

12.10.7. Required training topics include, but are not limited to:

12.10.7.1. Training GCAL and/or call center staff in out-of-State locations regarding State-specific requirements for emergency response, crisis intervention, call screening, triage and referral and associated performance requirements. Include training on Georgia geography and regions for the purpose of dispatching MCTs, recommending Providers and transporting members.
12.10.7.2. Agency and DBHDD training regarding the use of web-based systems and tools.
12.10.7.3. Customer service.
12.10.7.4. Application of utilization review, medical necessity, and LOC criteria with competency testing for inter-rater reliability.
12.10.7.5. Detection and reporting of suspected Fraud or Abuse.
12.10.7.6. Detection and reporting of suspected abuse, neglect, or exploitation as required by DBHDD Policy and State law.
12.10.7.7. Compliance with applicable federal and State law, rules and regulations, Contract requirements, and applicable ethical codes.
12.10.7.8. Waiver requirements and appropriate methods of measuring HCBS assurances.
12.10.7.9. PMs and guarantees.
12.10.7.10. Consumer and Individual rights.
12.10.7.11. Training requirements delineated in job descriptions.
12.10.7.12. Practice guidelines, EBPs, and best practices.
12.10.7.13. Security, privacy (HIPAA), and confidentiality requirements.
12.10.7.14. Reporting requirements.
12.10.7.15. Disaster recovery plans.
12.10.7.16. Contractor policy and procedure.
12.10.7.17. Overview of DBHDD programs and philosophy including approaches to

promote recovery and independence.

12.10.8. QM Reporting Requirements

12.10.8.1. The Contractor will submit a monthly implementation and status report regarding all QA requirements including HCBS required reports.

12.10.8.2. On a monthly, quarterly, and/or annual basis, as applicable, the Contractor will submit State-wide QM reports with detailed analysis of findings.

12.10.8.3. The statewide QM reports will include, at a minimum:

12.10.8.2.1 Significant review activity that occurred during the quarter.

12.10.8.3.2. Accomplishments.

12.10.8.3.3. Aggregate findings of the QEPRs, PRRs, NCIS results, FUTACs, and other Provider audits.

12.10.8.3.4. Analysis of significant findings.

12.10.8.3.5. Progress toward meeting QI performance and outcome measures.

12.10.8.3.6. Identification of patterns and trends, with reasoning for trends.

12.10.8.3.7. Identification of quality issues, with reasoning for issues.

12.10.8.3.8. Conclusions addressing areas of deficiencies and opportunities for QI in services and support provided to individuals.

12.10.8.3.9. Graphical presentation of da to allow for easy communication of results.

12.10.8.4. Recommendations will include, but are not limited to possible policy and procedure changes, best practices, training needs, educational seminars.

12.10.8.5. The annual statewide QM reports will include, but not be limited to:

12.10.8.5.1 An executive summary.

12.10.8.5.2 Major accomplishments.

12.10.8.5.3 Significant organizational changes.

12.10.8.5.4 Provider training curricula, evaluation results, and attendance records.

12.10.8.5.5 Dates of site visits and record selection.

12.10.8.5.6 Special reviews.

12.10.8.5.7 Provider concerns.

12.10.8.5.8 Individual concerns.

12.10.8.5.9 Recommendations to improve instruments and processes

12.10.8.5.10 Progress toward meeting PMs and outcome measures.

12.10.8.5.11. Summary of patterns and trends, quarterly and cumulative, with reasoning behind them.

12.10.8.5.12. Analysis and description of the data.

12.10.8.5.13. Aggregate findings from site visits by program type, aggregate findings of PRRs, NCIs results and QEPRs.

12.10.8.5.14. Conclusions addressing areas of deficiencies and opportunities for QI in services and support provided to Individuals.

12.10.8.5.15. Graphical presentation of data to allow for easy communication of results.

12.10.8.5.16. Assessment of the impact of the QM system on the service delivery system, and associated outcomes.

12.10.8.5.17. Identification of best and promising practices that demonstrate improvement in quality of services or generate high satisfaction with Individuals receiving those services.

12.10.8.5.18. Highlights of quality initiatives implemented by the State to improve quality of care for Individuals receiving DD services.

12.10.8.5.19. Recommendations for policy modifications and improvements to the QM process.

12.10.8.5.20. Recommendations for possible quality improvement studies.

12.10.8.6. The Contractor will work with DBHDD to develop an annual quality improvement study. Study topics will be proposed based upon data analysis and stakeholders' input. The quality improvement study will be implemented upon approval from DBHDD.

12.10.8.7. The Contractor will analyze NCIS data collectively and make recommendations to the State regarding quality improvement strategies.

12.10.8.8. Other reporting requirements as determined by DBHDD.

12.10.8.9. Ad Hoc Reports: The Contractor will produce Ad Hoc QM reports and data analysis at the request of DBHDD. Timelines for completion will be reasonable and determined at the time of the request. DBHDD expects to request approximately sixty (60) ad hoc QM reports per year.

12.10.8.10. Annually, the QM committee will report findings, recommendations, and actions to DBHDD's to inform shared objectives. The contractor will produce an annual report summarizing its activities including, but not limited to: audit processes, reporting activities, recommendations for updates to UM/UR criteria, and other QM and improvement initiatives.

12.11. Stakeholder Collaboration

12.11.1. The Contractor will provide a mechanism for input and participation of individuals, families/caretakers, Providers, DBHDD, and other stakeholders in determining strategies to improve service quality and outcomes.

12.11.2. The Contractor shall collaborate with State and local agencies, and related workgroups, and advisory and QI councils:

12.11.2.1. With DBHDD direction, the Contractor will participate in, provide educational and informational presentations, and lend expertise and support to certain QM entities such as the Behavioral Health Coordinating Council, Interagency Directors Teams, Centers of Excellence, BH and IDD Advisory/Quality Improvement Councils.

12.11.2.2. With DBHDD prior approval, the Contractor will meet and establish collaborative relationships with State and local agencies and other organizations and institutions likely to provide services or supports to Recipients and Individuals, or be the source of referrals for services including, but not limited to:

a. Georgia DCH;
b. Georgia DHS;
c. Department of Corrections;
d. State Board of Pardons and Paroles;
e. Courts (probate, state and superior, juvenile)
f. Sheriff's Association
g. Department of Education;
h. Emergency Service Providers, First Responders (Fire, Police);
i. Georgia Hospital Association;
j. Georgia CSB Association;
k. Georgia Department of Public Health;
l. Georgia Department of Juvenile Justice;
m. Georgia Department of Veteran's Services; and
n. Georgia Vocational Rehabilitation Agency.

12.11.2.3. These collaborative relationships and associated processes will include, as applicable:

a. Procedures to identify and address joint training needs;
b. Strategies to assist in diversion of Individuals from unnecessary institutional care; or
c. Exchange of information regarding services each provides.

12.11.3. Collaboration with individuals, peers, family members, Providers, and advocates.

12.11.3.1. In partnership with DBHDD, the Contractor will periodically meet with a broad spectrum of peers, individuals, family members, peer and family-run organizations, advocacy organizations, Advisory/QI Councils, and other persons that have an interest in participating in improving the system. The purpose of these meetings is to gather input, identify barriers, and problem-solve to strengthen the system.

12.11.3.2. At least bi-annually, the Contractor will make recommendations to DBHDD for updating UM/UR criteria with input from Providers, Individuals, Peers, Families, Advisory/QI Councils, and national

experts.

12.11.3.3. In partnership with DBHDD, the Contractor will periodically meet with a broad spectrum of Provider organizations, independent professionals, community-based Providers of services and supports, and others interested in participating in improving the system. The purpose of these meetings is to gather input, identify barriers and problem-solve to strengthen the system.

12.12. The Contractor will provide DBHDD with all relevant QM-related reports as required in this section and reference documents.

12.13. The Contractor will report to DBHDD regarding all relevant QM-related PMs and Qis in this section and Appendix 18, Initial Performance Measures.

13 Contractor PMs and Guarantees

The Contractor will:

13.1. Participate in the development, implementation, and refinement of PMs and PGs.

13.1.1. PMs and PGs will be calculated and reported using standard methodology established or adopted by the State, or as required by CMS in the approved HCBS assurances.

13.1.2. Unless directed by DBHDD or CMS, Contractor PMs and PGs apply to all populations served.

13.1.3. Initial PMs, as well as the definition, minimum performance standards, the reporting and measurement frequency are summarized in Appendix 18, PMs.

13.1.4. PGs for the Implementation Period (from Contract Award date through Go Live Date) will be based on the Contractor's attainment of goals and meeting deadlines in the approved version of the Contractor's implementation plan. Once the implementation plan is received and reviewed by DBHDD, the specific components of the plan to which PGs will be applied and the financial risk associated with each component will be determined in collaboration with the Contractor (See Appendix 42, PGs).

13.1.5. PGs for the initial year of the Contract, as well as the definition, performance standard, and financial risk associated with each measure are in Appendix 42, PGs.

13.1.6. PMs and PGs are subject to change on an annual basis.

13.2 PM Reporting

The Contractor will:

13.2.1. Submit to the DBHDD on a monthly, quarterly, semi-annual, and annual basis, data specified by the State that enables the State to evaluate Contractor performance relative to PMs.

13.2.2. Data collected for PMs will be returned by the Contractor in the format requested by the DBHDD and by the due date specified.

13.2.2.1. Any request for extension for additional time to collect and report data will be made by the Contractor to DBHDD in writing in advance of the initial due date. Request is subject to the approval of DBHDD.

13.2.3. The Contractor will take steps to attain and sustain performance at, or above, the minimum performance standard established for each PM. A minimum performance standard is the minimal acceptable level of performance by the Contractor.

13.2.4. Employ qualified staff to collect, analyze, and report data.

13.3 PM Performance

13.3.1. The Contractor may be subject to corrective action, notice to cure, or other remedies under this Contract for failure to attain minimum performance levels for Vendor/Contractor PMs.

13.3.2. Any statistically significant decline (as determined by DBHDD in conjunction with the Contractor) in the Contractor's performance level for any PM will be explained by the Contractor in its annual QM plan and evaluation.

13.4 PGs Performance

13.4.1. The Contractor will place twenty percent (20%) of its fees at risk for performance of the PGs as an incentive to perform to standard during contract year one. For all years thereafter the Contractor will place fifteen percent (15%) of its fees at risk for performance of the PGs as an incentive to perform to standard. Funds provided to Contractor for payment of providers are not included in the fees at risk.

13.4.2. Changes to the PGs or allocation of risk will be mutually agreed upon by DBHDD and the Contractor.

13.4.2.1. These changes will be finalized ninety (90) days prior to the beginning of the applicable measurement period. No changes may be made during initial contract year unless mutually agreed upon by DBHDD and Contractor.

13.4.2.2. Unless modified or terminated by mutual agreement of the parties, PGs will automatically renew at the beginning of each Contract year.

13.4.3. Incentive Calculations and Payment

13.4.3.1. Performance for each PG will be measured based on the results for the reporting period defined in each PG.

13.4.3.2. The determination of incentive payments will be based on the results for the reporting period defined for each PG, unless otherwise noted.

13.4.3.3. For monthly incentives, the fees at risk each month are defined as one-twelfth (1/12) of the annual amount set aside for the specific PG.

13.4.3.4. For quarterly incentives, the fees at risk each quarter are defined as one-fourth (1/4) of the annual amount set aside for the specific PG.

13.4.3.5. For semi-annual incentives, the fees at risk semi-annually are defined as one half (1/2) of the annual fees set aside for the specific PG.

13.4.3.6. For annual incentives, the fees at risk are defined as those fees paid during the year for the specific PG.

13.4.3.7. DBHDD will determine the total amount of performance incentives due.

13.4.3.8 Failure to meet a PG standard will result in an assessment of the associated amount.

13.4.3.9 In the event of termination of the Contract, any monies owed with respect to the PGs will be paid within forty-five (45) days of the termination date.

13.5 PG Reporting

The Contractor will:

13.5.1. Provide monthly, quarterly, semi-annual, or annual results (“Reporting Periods”) in one consolidated document, at the frequency specified for each PG.

13.5.2. For monthly, quarterly, and semi-annually reported metrics, the Contractor will also provide year-to-date annualized results throughout the year in the consolidated document.

13.5.3. Monthly, quarterly, and annual reports regarding PG performance are due to the State according to the timelines (see Appendices 18, 26, 42).

13.5.4. Results for PG measurement purposes will be based on the Contractor’s self-reported results.

13.5.4.1. When requested, the Contractor will provide source documents in support of self-reported results.

13.5.4.2. All PG results are subject to verification and audit by DBHDD or its

designee.

13.5.4.3. An audit may be performed each year covering a three (3) or more month period of the PG year for claims quality results.

13.5.4.4. The audit will employ a financial-stratified or attribute-statistical sampling methodology.

13.5.4.5. If the results of the audit are below the Contractor's self-reported results for the period under review, the Contractor will have forty-five (45) days to respond to a written copy of the audit report.

13.5.4.6. If the Contractor's response does not, in the State's estimation, satisfactorily account for the discrepancy in results, then the audit results will be the basis for PG measurement and incentive determination. This provision will remain in effect until such time as the Contractor demonstrates consistent reliability of its self-reported results (i.e., self-reported results are consistent with audit results) and subject to mutual agreement by the parties.

14 Claims Payment and Claims Customer Service

Overview and General Requirements

14.1.1. The Contractor is not responsible for payment of Medicaid Claims; the Medicaid GAMMIS vendor (currently HP) pays Claims for Medicaid services.

14.1.2. The Contractor's Medicaid Claims payment role is limited to eligibility verification.

14.1.3. The Contractor will submit authorizations for Medicaid services to the GAMMIS to allow Claims payment. (See Sections 4. Eligibility and Enrollment and 8. UM/UR).

14.1.4. The Contractor will pay non-Medicaid Claims consistent with grant funding and DBHDD policies, procedures, and requirements. Contractor will establish a Claims payment schedule that processes and pays Claims at a minimum weekly.

14.1.5. The Contractor will make all payments to Providers electronically via Electronic Funds Transfer (EFT) or check.

14.1.6. State-funded payment methodologies include:

14.1.6.1. FFS Claims.

14.1.6.2. Expense reimbursement for goods and services rendered during an authorized period (NCB) payments.

14.1.6.3. Annual expense allocation paid via monthly payments and tracked through an encounter-based system (Encounters). For encounter-based systems, the Contractor will:

14.1.1.1.1. Collect and accept encounter submissions.

14.1.1.1.2. Not make payments to Providers. DBHDD will pay Providers.

14.1.1.1.3. Reconcile completeness of encounters with DBHDD payments.

14.1.1.1.4. Contractor will prepare reports that compare DBHDD payments and the value of encounters reported.

14.1.7. The Contractor will serve as the fiscal intermediary for State-funded FFS Claims and Claims payment; and when processing payments for the following NCB services:

14.1.7.1. Housing vouchers.
14.1.7.2. Bridge funding.
14.1.7.3. Transition funding (IDD Individuals).

14.1.8. The Contractor will provide telephonic Claims customer service to facilitate non-Medicaid Claims payment and encounter adjudication, resolve problems, and otherwise meet the requirements of this Contract.

14.2 Claims Operations Requirements

14.2.1. For State-funded FFS Claims and encounter-based systems, the Contractor is responsible for Individual or Recipient enrollment verification, Provider enrollment verification, Claims edits, benefit determination, coordination of benefits with third parties, application of sliding fee scales, copayments and deductibles, Claims adjudication, Claims payment, Claims customer service, Claims documentation and reporting.

14.2.2. The Claims processing functions include:

14.2.2.1. Capture and adjudication of State-funded Claims submitted by Providers for payment.
14.2.2.2. Making Claims payments according to State-negotiated Provider reimbursement rates for BH and IDD State-funded services.
14.2.2.3. Ensuring Claims are consistent with approved authorizations, prior to making payments.
14.2.2.4. Basing payment amounts on Provider fees minus copayments, coinsurance, third-party liability and sliding scale fees due from the individual or Recipient. DBHDD expects this capacity to be included in the IS and to be implemented during Year 2 of the contract.

14.2.3. The Claims processing and encounter adjudication functions include:

14.2.3.1. Ensuring the accurate and timely processing of Claims and encounter adjudications.
14.2.3.2. Verifying services paid or encountered were actually delivered (e.g., documentation that supports NCB reimbursement is submitted).
14.2.3.3. Collecting other insurance information and coordinating benefits accordingly.
14.2.3.4. Ensuring FFP is sought in the funding of services as appropriate.
14.2.3.5. Maintaining Claim, NCB expense reimbursement and receipts, and encounter history in a manner that supports reporting

requirements, UM/UR, QM, financial audits, and other requirements.

14.3 Claims System Requirements

The Contractor will:

14.3.1. Implement an integrated encounter, NCB reimbursement, and State FFS Claims payment and processing system that includes:

14.3.1.1. Collections of electronic submissions, including those from clearinghouse, electronic transmission, and direct data entry.
14.3.1.2. Sufficient edits (e.g., National common coding initiative (NCCI), eligibility, valid values, etc.) to:
14.3.1.2.1. Ensure the accurate payment of claims;
14.3.1.2.2. Detect Fraud, Waste, and Abuse consistent with Section 3.3.5.; and
14.3.1.2.3. Ensure the accuracy and completeness of the Claims that are submitted.
14.3.1.3. Capacity to collect unique rendering Provider numbers on Claims information that identifies direct care workers not required to obtain a NPI as outlined in Section 3.
14.3.1.4. Maintenance of the receipt date for each document received (e.g., authorization, Claim).
14.3.1.5. Retention of history of adjudicated Claims and authorization data for verifying duplicates, checking service limitations, and historical reporting.

14.3.2. The Contractor will support and encourage electronic submission of Claims and encounters for all Claim types; however, the Contractor will have the capacity to receive hardcopy (i.e., paper) as an alternative when electronic submission is not possible.
14.3.2.1. Hard copy submissions may include initial submissions and adjustment Claims and encounters.
14.3.2.2. Electronic submissions include clearinghouse, electronic transmission, and direct data entry.
14.3.2.3. The Contractor will conform to HIPAA-compliant standards and requirements. Transaction types are subject to change and the Contractor will timely comply with applicable federal standards and regulations as they become effective.
14.3.2.4. The Contractor may use any clearinghouse(s) and/or alternatively provide for electronic submission directly from Providers to the Contractor.
14.3.2.5. The system will maintain the receipt date for each document (i.e., Claim, encounter, referral, reimbursement request, authorization, or adjustment) and track the processing time from date of receipt to final disposition.

14.3.3. The Contractor will offer Providers an electronic payment option via ACH/EFT.

14.3.3.1. For electronic remittance advices, the Contractor will offer Providers:

14.3.3.1.1. A secure file transfer option

14.3.3.1.2. A secure portal for viewing remittance advices (in PDF or other report friendly format); and

14.3.3.1.3. An option to download the HIPAA 835 5010 remittance file.

14.3.3.1.4. Consolidated and separate remittance advices for 1) encounters received and accepted, but not paid by the Contractor, with the value of encountered services depicted as units multiplied by rate, and 2) value of the Claims paid by the Contractor on an FFS basis 3) NCB reimbursement.

14.4 Claims QM

14.4.1. The Contractor will perform front-end system edits including, but not limited to:

14.4.1.1. Eligibility confirmation for each Individual and Recipient as Claims are submitted that applies to the period during which the charges were incurred;

14.4.1.2. Validation that medical necessity was determined (e.g., authorization validates medical necessity);

14.4.1.3. Determination that a service was authorized for the period during which the charges were incurred;

14.4.1.4. Flags for duplicate Claims when a Claim is exactly the same as a previously submitted paid Claim, or a possible duplicate, and either deny or pend the Claim as needed;

14.4.1.5. Verification that a service is a covered service and is eligible for payment;

14.4.1.6. Verification that a Provider is eligible for payment for the service delivered and Claims submitted;

14.4.1.7. Verification that applicable benefit limits are applied; and

14.4.1.8. System edits for valid dates of service, (e.g., as dates are not in the future or outside of a Recipient's eligibility span).

14.4.2. The Contractor will adhere to national standards, instructions, and definitions for internal Claim processing audits.

14.4.2.1. On every Claim-processing day, the Contractor will audit a randomly selected sample of all processed, adjusted, and paid/denied Claims.

14.4.2.2. A minimum sample of two percent (2%) of daily Claims will be audited.

14.4.2.3. Results from the audits will be collected and reported to the State.

14.4.3. The minimum attributes to be tested for each Claim audited will include, but are not limited to:

14.4.3.1. Claim data correctly entered into the Claims processing system with an assigned transaction number;

14.4.3.2. Claim is associated with the correct Provider;

14.4.3.3. Proper authorization was obtained;
14.4.3.4. Authorization limits were not exceeded;
14.4.3.5. Individual and Recipient eligibility on processing date correctly applied;
14.4.3.6. Allowed payment amount agrees with contracted rate;
14.4.3.7. Duplicate payment of the same Claim has not occurred;
14.4.3.8. Denial reason applied appropriately;
14.4.3.9. Co-payment application considered and applied;
14.4.3.10. Effect of modifier codes correctly applied;
14.4.3.11. Proper receipts or invoices were received to justify payment, when applicable.
14.4.3.12. Adjustments to Claims were properly made with supporting documentation;
14.4.3.13. Payment was coordinated properly when other insurance exists, if applicable.

14.4.4. Audit results will include at a minimum:
14.4.4.1. Results for each attribute with errors for each Claim selected;
14.4.4.2. Amount of overpayment or underpayment for each Claim processed, adjusted, or paid in error;
14.4.4.3. Explanation of the erroneous processing for each Claim processed, adjusted, or paid in error;
14.4.4.4. Determination if the error was the result of a keying error or the result of error in the configuration or table maintenance of the Claims processing system (if possible);
14.4.4.5. Claims processed, adjusted, or paid in error have been corrected.

14.4.5. If a Claim is denied because the Provider did not submit required information or documentation with the Claim, then the remittance advice or other written or electronic notice will identify all information and documentation necessary for the Claim to be processed.

14.4.4. Resubmission of a Claim with further information and/or documentation will constitute a new Claim for purposes of establishing the time frame for Claims processing PMs and PGs.

14.5 For NCB services payments, the Contractor is responsible for implementing the following procedures:

14.5.1. Housing vouchers (rental assistance):
14.5.1.1. The Contractor will process and disburse payments for the Georgia Housing Voucher Program (GHVP) consistent with the policies and procedures outlined in the program description (see Appendix 32).
14.5.1.2. The Contractor will receive and process documentation and information necessary for rental assistance payments via upload through secure web portal or data entry by DBHDD staff. This information includes information about the individual served, landlord information, and rental amounts.
14.5.1.3. The Contractor will process recurring monthly payments to property owners with provisions to stop payments to a landlord because an Individual has moved or left the program or change payment amounts because of a change in rental agreement.
14.5.1.4. The Contractor will pay property owners/landlords on or before the

first (1st) of every month for recurring monthly rents.

14.5.1.5. The Contractor will be responsible for any late fees incurred if it is determined that the Contractor failed to make timely payments.

14.5.1.6. The Contractor will work with DBHDD staff to resolve rental assistance payment issues.

14.5.1.7. As of July 1, 2013, there were seven hundred and sixty-two (762) registrants housed and another seventy-nine (79) in housing search. There are approximately three hundred and fifty (350) properties under contract and forty-five (45) housing Providers are actively serving registrants. The average monthly rental payment was five hundred and nine dollars and fifty-four cents ($509.54).

14.5.2. Bridge Funding

14.5.2.1. Bridge funding supports Individuals transitioning from institutions to supported housing during the time needed for Individuals to become eligible for, and a recipient of other supplemental income.

14.5.2.2. DBHDD will provide to the Contractor a list of approved bridge funding Providers who are permitted to submit Claims for provision of eligible goods and services. Updates will be made when providers are added or removed.

14.5.2.3. DBHDD will provide guidance related to expenses which may be reimbursed and limits to amounts.

14.5.2.4. Using the Contractor's web-based authorization system, providers will submit Claims for goods and services.

14.5.2.5. The Contractor will review Claims and approve payment based on guidelines and receipt of supporting documentation (e.g., receipts or other similar evidence of expenses). The Contractor's system will allow for submission of receipts via secure web portal or hard copy via mail.

14.5.2.6. In 2013, bridge funding was provided to three hundred and eighty-three (383) Individuals. The average cost per individual was three-thousand two-hundred and forty-seven dollars ($3,247). Furnishings and first- and second-month rent accounted for fifty percent (50%) of the costs; and Provider fees accounted for twenty percent (20%) of the expenditures. The remaining funds were allocated for household items, food, transportation, medications, moving expenses, utility and security deposits, and other expenses.

14.5.3. Transition Funding

14.5.3.1. Transition funding supports Individuals transitioning from institutions to community-placements. Transition funding is available to approved IDD Individuals

14.5.3.2. Transition funding categories include, but are not limited to:

14.5.3.2.1 Peer community support;

14.5.3.2.2 Trial visits with personal support services;

14.5.3.2.3 Household furnishings;

14.5.3.2.4 Household goods and supplies;

14.5.3.2.5 Moving expenses;

14.5.3.2.6 Utility deposits;

14.5.3.2.7 Security deposits;
14.5.3.2.8 Transition support;
14.5.3.2.9 Transportation;
14.5.3.2.10 Community transition financial services;
14.5.3.2.11 Skilled out-of-home respite;
14.5.3.2.12 Caregiver training;
14.5.3.2.13 Equipment and supplies;
14.5.3.2.14 Vehicle adaptations; and
14.5.3.2.15 Environmental modifications.

14.5.3.3. DBHDD reviews Provider requests for bridge funding and approves planned budget for the purchase of services and goods for Individuals transitioning to the community.

14.5.3.4. DBHDD will provide to the Contractor a list of approved transition funding Providers who are permitted to submit Claims for eligible goods and services. Updates will be made when Providers are added or removed.

14.5.3.5. Provider agencies identify and determine the Individual's needs and develop a proposed budget for the Individual who will be transitioned. DBHDD reviews Provider requests for transition funding and will enter approved budgets into Contractor's authorization system.

14.5.3.6. Using the Contractor's web-based authorization system, providers will submit Claims for goods and services.

14.5.3.7. The Contractor's system will allow for submission of receipts or invoices for eligible expenses that were DBHDD-approved through the secure web portal or hard copy, via mail.

14.5.3.8. The Contractor will review Claims and approve payment based on guidelines and receipt of supporting documentation (e.g., receipts or other similar evidence of expenses). Claims will be paid within five (5) business days of receipt of supporting documentation.

14.5.3.9. DBHDD will provide guidance related to expenses that may be reimbursed and limits to amounts.

14.5.3.10. The Contractor will provide DBHDD with monthly financial reports.

14.5.3.11. There may be some special circumstances in which the transition funding must be paid in advance. DBHDD will work with the Contractor to identify a process for these payments.

14.5.4. Quality Monitoring and Reporting

14.5.4.1. The Contractor will work with DBHDD and Providers to monitor the timeliness and quality of the Claims-related services delivered to Individuals and Providers.

14.5.4.2. The Contractor will provide Claims and encounter auditing reports on a monthly, quarterly, and annual basis.

14.5.4.3. The Contractor will provide monthly, quarterly, and annual reporting that details the housing, bridge, and transition funding costs for the previous quarter, the names of the Individuals on whose behalf payment was made, the Provider that received payments, the goods and services received and associated fees.

14.5.4.4. On a monthly basis, the Contractor will report the number and dollar amount for all authorizations outstanding for State-funded services on

a year-to-date basis, including authorizations for FFS Claims, housing vouchers, transition funding, and bridge funding.

14.5.4.5. The Contractor will work with State to design reports that allow accurate cash flow predictions for State budgeting purposes.

14.5.4.6. The Contractor will provide the Department with reports of potential financial recoupment opportunities identified during Claim-audits as applicable.

14.5.4.7. The Contractor will meet Claims-related performance standards, including Claims payment timeliness and accuracy performance standards as described in the Section 13. PMs and Guarantees.

14.5.4.8. The Contractor will submit all required reports as described in this section and the list in Appendix 26, Deliverables and Reports Matrix.

14.5.4.9. The Contractor will document and report its performance relative to all claims-related PMs and PGs as described in this section and Appendices 18 and 42.

14.6 Claims Customer Service

14.6.1. The Contractor will hire and train a sufficient number of Claims processing staff and supervisors to conduct timely and accurate State-funded Claims payment, encounter processing, NCB services reimbursement and otherwise meet the requirements of this Contract.

14.6.2. The Contractor will hire and train a sufficient number of Claims representatives to provide timely telephonic customer service for State-only Claims inquiries, facilitate State-funded Claims payment, encounter processing, NCB services reimbursement, resolve issues, and otherwise meet the requirements of this Contract. Any Providers inquiries related to Medicaid authorizations will be promptly addressed within five (5) days. Provider inquiries regarding Provider payment will be forwarded to GAMMIS. If there is a question regarding a Provider inquiry that is both a Medicaid authorization and payment issue, the Contractor will work with GAMMIS to resolve the issue within thirty (30) days.

14.6.3. Claims representatives and processing staff will be responsible for entering data into the information system (IS), reviewing Claims, and identifying missing information and Claims processing errors.

14.6.4. Claims representatives will be available during business hours and will respond to telephonic Claims inquiries with an average speed of answer of thirty (30) seconds and an abandonment rate of less than five percent (5%) during business hours. (See Section 13. PMs and Guarantees.)

14.6.5. Claims representatives will successfully resolve telephonic Claims inquiries that cannot be resolved on the telephone, within five (5) business days of the Claims inquiry. (See Appendix 18, PMs.)

14.6.6. Ninety percent (90%) of clean Claims will be paid within fourteen (14) days of receipt. Ninety-nine percent (99%) of all Claims will be processed within thirty (30) days of receipt. (See Section 13 and 42, PMs and PGs.)

14.6.7. Claims payment dollar accuracy will be at ninety-nine percent (99%). (See Appendix 18, PMs)

14.6.8. Claims payment incidence accuracy will be a ninety-seven percent (97%). (See Appendix 18, PMs)

14.7 Claims Payment, Post-Contract Termination

At Contract termination, the Contractor will supply all information necessary to DBHDD or its designee for reimbursement of outstanding Claims.

15 IS and Data Exchange

15.5 Overview and General Requirements

15.1.1. The Contractor will provide state-of-the-art technologies that create efficiencies and improve the quality of care, leading to better outcomes while containing costs. The technological capability will reduce administrative costs and diminish duplicative procedures, paperwork, and overhead for DBHDD and its Provider Network.

15.1.2. The Contractor will develop and implement comprehensive, internal policies and procedures that address Information Technology (IT) processes and requirements.

15.1.3. The Contractor will provide help desk assistance for Contractor staff, DBHDD staff, Individuals, Providers, and other IS users.

15.1.4. The Contractor will fully and effectively implement the IS requirements within (120) one-hundred and twenty days of the Contract Award date or no later than sixty (60) days prior to “Go Live”, whichever is later, unless a different implementation date for a specific IS component is specified in this Contract.

15.1.4.1. System implementation will include adequate IT testing to assure all systems are functional on the “Go Live Date” as evidenced in the proposed implementation plan.

15.1.5. The Contractor will implement all aspects of this section in compliance with current and future federal and State-specific laws, rules, regulations, requirements and standards for system requirements, data exchange, privacy, security and the timely collection, storage and reporting of data and will ensure that all Subcontractors comply with all such requirements for all information systems involved in the work related to this contract.

15.1.6. The Contractor will make modifications to the IS during the term of the Contract to reflect changes in DBHDD, DCH, State and/or federal requirements to include, but not limited to those changes required by the ADA Settlement Agreement. Such updates will be made at agreed upon intervals, and notice of such updates, given to impacted service Providers (preferably via electronic means), DBHDD Staff, and other end users as soon as feasible.

15.1.6.1. The Contractor shall plan for any future revisions of diagnostic or procedure codes.

15.1.7. The IS will be organized in a user-centric manner, with readily accessed data that is easily converted into relevant and meaningful reports, and presented so as to provide a comprehensive view of an Individual's services, including authorizations, utilization, outcomes, and interactions with the service delivery system. All information regarding an Individual will have accessibility based on applicable laws and authorizations/consents for disclosure by the individual.

15.1.8. The IS will include an architecturally distinct, reusable reporting service that facilitates various types of reports including, but not limited to:

15.1.8.1. Static (canned) reports.

15.1.8.2. Dynamic (parameter-driven) reports.

15.1.8.3. Ad-hoc reports based on user needs.

15.1.8.4. GCAL, performance, management, and executive Dashboards for data visualization, tracking and trending, with the capacity for data drill-up and drill-down based on user needs.

15.1.9. The IS and data exchange section delineates specific IS requirements; however, additional requirements and additional context for these IS requirements will be found in associated sections (e.g., GCAL system requirements are contained in both Section 6. GCAL and this section).

15.2 Systems Development and Operations

15.2.1. The Contractor's system will have the capacity for:

15.2.1.1. High speed internet access with required sustained bandwidth of 30kbs per standard concurrent connected user.

15.2.1.1.1. Power users, heavy reporting, or file uploads/downloads may require additional bandwidth.

15.2.1.2. Environments

15.2.1.2.1. Multiple environments.

15.2.1.2.2. Multiple instances of environments.

15.2.1.2.3. Creation of new instances of environments.

15.2.1.2.4. Tools to replicate, initialize, or populate the environment.

15.2.1.2.5. Complete environments with all components for distinct units of work.

15.2.1.2.6. The system will provide, at a minimum, the following standard deployment environments:

15.2.1.2.6.1. Development.

15.2.1.2.6.2. Test.

15.2.1.2.6.3. User Acceptance.

15.2.1.2.6.4. Training.

15.2.1.2.6.5. Production.

15.2.1.3. Testing

15.2.1.3.1. The Contractor will utilize a proven and well-established formal testing methodology across the software development lifecycle.

15.2.1.3.2. The Contractor's testing methodology will provide

and address the following test cycles, at a minimum:

15.2.1.3.2.1. Unit testing.
15.2.1.3.2.2. Integration testing.
15.2.1.3.2.3. Performance testing.
15.2.1.3.2.4. Load testing.
15.2.1.3.2.5. Stress testing.
15.2.1.3.2.6. Capacity testing.
15.2.1.3.2.7. Data conversion testing.
15.2.1.3.2.8. User acceptance testing.
15.2.1.3.2.9. Disaster recovery testing.

15.2.2. System Operations

15.2.2.1. Scheduled Maintenance

15.2.2.1.1. The Contractor will establish monthly maintenance windows for the purpose of upgrading, patching, modifying, and repairing portions of the system.
15.2.2.1.2. The schedule will reasonably align with the State's preferred schedule of 1:00 AM – 3:00 AM Eastern Time (ET).
15.2.2.1.3. In the event that emergency maintenance is required, the Contractor will ensure that it occurs during 7:00 PM – 5:00 AM (ET).

15.2.2.2. Major System Upgrades

15.2.2.2.1. The Contractor will develop a system change plan when changing or making major upgrades to the IS affecting UM/UR, Claims processing, or any other major business component.
15.2.2.2.2. The system change plan will include a timeline, milestones, and adequate testing before implementation.
15.2.2.2.3. At least six (6) months before the anticipated implementation date, the Contractor will provide the system change plan to the State for review and comment.
15.2.2.2.4. Sixty (60) days prior to the expected implementation of a material change to Contractor operations, the Contractor will submit a request for approval of a material change to the State, including a draft notification to affected Individuals/Recipients, Providers, and other users. Include in the request, at a minimum:

15.2.2.2.4.1. Information regarding the nature of the operational change;
15.2.2.2.4.2. The reason for the change;
15.2.2.2.4.3. Methods of communication to be used; and
15.2.2.2.4.4. The anticipated effective date.

15.4.14.5.3. Provide thirty (30) days advance notice to affected Providers and other users of the material change in

Contractor operations.

15.2.2.3. Modifications and Enhancements

15.2.2.3.1. At least ninety (90) days prior to major system modifications or enhancements (e.g., those impacting Provider interfaces, file layouts within the Contractor's systems), the Contractor will notify Providers, DBHDD Staff, and other end-users of the change, including detailed requirements for new information or procedures the end-users must provide or implement.

15.2.2.3.2. At least thirty (30) days prior to minor modifications or enhancements (e.g., those not impacting Provider interfaces, file layouts within the Contractor's systems), the Contractor will notify Providers, DBHDD Staff, and other end-users of the change, including detailed requirements for the changes being made, new information, or procedures that must be implemented.

15.2.2.3.3. DBHDD may require more time so Providers have sufficient time to accommodate the changes made.

15.2.2.3.4. Contractor will notify DBHDD of any changes that may require amendments to the DBHDD HIPAA Notice of Privacy Practices (see Notice of Privacy Practices Policy 23-101; https://gadbhdd.policystat.com/policy/574979/latest/)

15.2.3. System Availability

15.2.3.1. The performance standard for IS availability is ninety-nine percent (99%) with the following exceptions. (See Section 13. PMs and Guarantees for more information.)

15.2.3.1.1. Circumstances beyond Contractor's reasonable control including acts of any governmental body, war, insurrection, sabotage, armed conflict, embargo, fire, flood, collectively known as Force Majeure situations.

15.2.4. System Compliance

15.2.4.1. The Contractor will make available all components of the IS system for review or audit upon request by the State.

15.2.4.2. The Contractor will document practices for encryption, access monitoring, security, and privacy audits.

15.2.4.3. The Contractor and any sub-contractors, will retain an independent third-party to perform a HIPAA security and privacy audit.

15.2.4.3.1. Subsequent audits shall be performed annually and must include a review of Contractor's compliance with all security and privacy requirements.

15.2.4.4. Contractor's independent audit report will address:

15.2.4.4.1. A review of Contractor policies and procedures to

verify that appropriate security and privacy requirements have been adequately incorporated into the Contractor‘s business practices.

15.2.4.4.2. A review of the automated and/or manual scans of the production processing systems to validate compliance.

15.2.4.4.3. When necessary, a remediation plan, which describes:

15.2.4.4.3.1. All issues and discrepancies between the security/privacy requirements and the Contractor‘s policies, practices, and systems; and

15.2.4.4.3.2. Timelines for corrective actions related to all issues or discrepancies identified in the remediation plan.

15.2.4.4.3.3. The remediation plan must be submitted to the State for review, approval, and be subject to verification and compliance through regular monitoring activities.

15.2.4.4.3.4. The Contractor shall submit the initial audit report on or before the Go-Live and the subsequent annual audit reports within ninety (90) days of the start of each Contract year.

15.3 Systems Functions and Capacity

15.3.1. The Contractor will establish and maintain an IS that collects, stores, and produces meaningful reports for the purposes of financial, clinical, operational, and management functions; and serves as an efficient communication vehicle for the DBHDD delivery system. At a minimum, the IS will support the following functions:

15.3.1.1. An integrated client IS that integrates all information about a person served into one location, which is searchable, and current. Information included, but not limited to:

15.3.1.1.1. Demographic information, including information such as:

15.3.1.1.1.1. ADA target population status

15.3.1.1.1.2. Employment status

15.3.1.1.1.3. Housing status

15.3.1.1.1.4. Other information captured in the MICP (see Appendix 17a-f)

15.3.1.1.2. ISP’s (IDD Individuals).

15.3.1.1.3. UM/UR (services authorized).

15.3.1.1.4. Crisis Events (GCAL).

15.3.1.1.5. Hospitalizations.

15.3.1.1.6. Services received (Claims/encounter data).

15.3.1.1.7. Clinical, diagnostic, and outcomes information.

15.3.1.1.8. Critical Incidents.

15.3.1.2. Electronic verification of Individual and Recipient enrollment in Medicaid, third-party insurance or other coverage.

15.3.1.3. The Contractor may propose the use of a sub-contracted third-party vendor for the verification of insurance.

15.3.1.4. Verification of Individual eligibility and enrollment in State-funded programs:

15.3.1.4.1. In collaboration with DBHDD and other State agencies (e.g., Department of Labor, Department of Revenue), support the verification of financial eligibility.

15.3.1.4.2. Enrollment in State-funded services and supports.

15.3.1.4.3. Verification of Provider enrollment.

15.3.1.5. Capacity to collect and store data related to IDD Intake and Evaluation:

15.3.1.5.1. Assessment tools and results, and ISP development, modification, and tracking including, but not limited to:

15.3.1.5.1.1. SIS.

15.3.1.5.1.2. Health risk screening tool.

15.3.1.5.1.3. Social work assessment.

15.3.1.5.1.4. Nursing assessment.

15.3.1.5.1.5. Psychological assessment.

15.3.1.5.2. Collection and storage of documents such as Individual Support plans, eligibility documents, medical, and psychological evaluations (e.g., documents in PDF, Word formats).

15.3.1.6. Compliance activities.

15.3.1.7. GCAL services, including:

15.3.1.7.1. Rapid and coordinated crisis response and stabilization.

15.3.1.7.2. Operation of a twenty-four/seven (24/7) call center and access line.

15.3.1.7.3. GCAL live and interactive Dashboard for admission review and bed availability (see Appendix 10 and 23 for sample information).

15.3.1.7.4. A community resource database available to GCAL staff with non-DBHDD resources available (e.g., United Way, Homeless Shelters).

15.3.1.8. UM/UR functions including, but not limited to:

15.3.1.8.1. Processing authorization requests, submissions, and status checks.

15.3.1.8.2. Provide authorization to DBHDD BH crisis providers (e.g.,State-contracted community hospitals, CSUs) that will not require the Providers to submit an authorization request through UM/UR processes. Claims or encounters could then be submitted against this authorization.

15.3.1.8.3. Provider, Individual, and Recipient outlier management.

15.3.1.8.4. Promoting high quality care through application of

practice guidelines and EBPs in the review Intensive BH and DD Services.

15.3.1.8.5. Removing barriers to discharge and transition planning.

15.3.1.8.6. Facilitating communication between Providers and other agencies to promote effective care coordination and collaboration.

15.3.1.8.7. Documentation of denials and NOAA.

15.3.1.8.8. Development of Provider profiles

15.3.1.9. QM functions including, but not limited to:

15.3.1.9.1. Implementation of the Contractor's internal QM Program and supporting DBHDD's QM Program.

15.3.1.9.2. Implementation and measurement of the HCBS QA.

15.3.1.9.3. Performance monitoring relative to Qis, PMs, PGs.

15.3.1.9.4. PRRs, QEPRs, FUTAC, and BH audit processes, results, and reporting.

15.3.1.9.5. Incident monitoring and reporting related to Contract functions.

15.3.1.9.6. Provider and Contractor staff training activities, attendance documentation, and competency testing.

15.3.1.9.7. Stakeholder collaboration.

15.3.1.9.8. Provider Performance Profiles.

15.3.1.9.9. Receive monthly Medicaid Claims file of outpatient, inpatient, emergency room, and pharmacy claims for Recipients.

15.3.1.10. Network Management functions including, but not limited to:

15.3.1.10.1. An online Provider resource directory.

15.3.1.10.2. Prequalification, verification, and network enrollment of Providers.

15.3.1.10.3. Network adequacy assessment.

15.3.1.10.4. Network accessibility monitoring.

15.3.1.11. Financial management.

15.3.1.12. Claims payment and encounter processing functions which include, but are not limited to:

15.3.1.12.1. Claims payment, encounter processing, and reimbursement of State Providers.

15.3.1.12.2. Claims customer service.

15.3.1.12.3. Fraud and Abuse detection.

15.3.1.13. Data management and reporting.

15.3.1.14. Compliance monitoring.

15.3.1.15. Contract management.

15.4 Website and Web-Based Systems

15.4.1. The Contractor will maintain a website(s), that includes:

15.4.1.1. Public access and secure access utilizing user id's and passwords.

15.4.1.2. Critical information must also be available in Spanish and text that is accessible to individuals with visual impairment.

15.4.1.3. Multi-level user rights (e.g., Providers, DBHDD staff/managers/executives, and Individuals, Recipients, family

members/caretakers).

15.4.1.4. At a minimum, the following information:

15.4.1.4.1. GCAL information and phone number.

15.4.1.4.2. Approved educational materials, including practice guidelines, EBPs, best practices, national trends, etc.

15.4.1.4.3. Manuals.

15.4.1.4.4. Handbooks.

15.4.1.4.5. Provider resource directory.

15.4.1.4.6. Provider applications.

15.4.1.4.7. Data interface companion guides.

15.4.1.4.8. Access to web-based systems (see below). 15.4.1.4.9. Web-based Provider training.

15.4.1.4.10. Standard reports and ad hoc reporting tools.

15.4.1.4.11. Frequently asked questions (FAQs).

15.4.1.4.12. Community forums schedule.

15.4.1.4.13. Information on how to report Fraud and Abuse. 1

15.4.1.4.14. DBHDD specific information, forms, etc. such as:

15.4.1.4.14.1. DBHDD HIPAA Complaint Form.

15.4.1.4.14.2. DBHDD HIPAA Violation Report Form.

15.4.1.4.14.3. Information on how to report abuse, neglect, or exploitation.

15.4.1.4.15. A searchable communications or notices section where communications from the State or Contractor can be posted for Provider or public viewing.

15.4.1.4.15.1. Communications may be in text or document format.

15.4.1.4.15.2. Users may sign up to receive notification that a communication has been posted.

15.4.1.4.15.3. Hyperlinks to the State's other websites.

15.4.1.4.15.4. Data access as needed for the effective management and evaluation of the performance of the Contractor, Providers, and the service delivery system.

15.4.1.4.16. Training Information

15.4.1.4.16.1. Announce training events and post calendar in collaboration with DBHDD training announcements and calendars.

15.4.1.4.16.2. Make available current/historic training products and materials as an online resource center.

15.4.2. The Contractor will develop and maintain the following secure web portals and associated web-based systems to serve as communication vehicles between stakeholders, DBHDD, and the Contractor and support the following functions:

15.4.2.1. Generation of unique identification number (CID).
15.4.2.2. Application for BH State-funded services.
15.4.2.3. Application for IDD services (HCBS and/or State-funded). See Appendix 41, I&E Applicant Information
15.4.2.4. Provider applications.
15.4.2.5. GCAL bed capacity Dashboard.
15.4.2.6. HCBS data management system.
15.4.2.7. NCB services authorization and payment system.
15.4.2.8. Service authorization system.
15.4.2.9. Claims payment and encounter submission system.
15.4.2.10. Provider resource directory.
15.4.2.11. Provider Performance Profiles.
15.4.2.12. Reporting tools.
15.4.2.13. IDD QI council portal.
15.4.2.14. IDD human rights council portal.

15.4.3. Generation of Unique Identification Numbers (CID)

The Contractor will design a web-based system that at a minimum:

15.4.3.1. Registers all Individuals being served by DBHDD's service delivery system (i.e., GCAL, State hospitals, State-contracted psychiatric hospitals, community BH services, community IDD services, etc.).
15.4.3.2. Uses a methodology to search and match Individual's information (e.g., Soundex), using data elements such as:
15.4.3.2.1. Last name.
15.4.3.2.2. First Name
15.4.3.2.3. Date of Birth
15.4.3.2.4. Last four digits of Social Security Number
15.4.3.2.5. Medicaid Number
15.4.3.3. Identification numbers do not change when demographics change (e.g., change in last name for marriage/divorce, adoption, etc.).
15.4.3.4. The system will have the ability to automatically generate a CID using electronic files such as eligibility or authorization files utilized in the system without user interaction with the website.
15.4.3.5. Capable of generating a CID when all of the demographic information is not known (e.g., when an Individual is in crisis, Individual does not have a Social Security number, etc.).
15.4.3.6. Links this CID number to all client records in the system.
15.4.3.7. Crosswalks of any internal system consumer ID numbers to State recognized CID numbers (e.g., State generated IDs, Medicaid IDs, etc.) for use in communication with the State.
15.4.3.8. Loading of temporary Recipients when Recipient is eligible, but cannot be located in electronic eligibility databases.
15.4.3.9. The Contractor will receive from DBHDD a one-time data file upload of all existing CIDs in DBHDD's system.
15.4.3.10. Contractor will propose a process to DBHDD that the Contractor will use for the merging or consolidation of consumer records when it has been identified that an Individual has multiple CIDs.

15.4.4. State-Funded Services Application Web-Based System Components The Contractor will design a web-based system that at a minimum:

15.4.4.1. Permits benefit information review.

15.4.4.2. Permits Individuals and Recipients to apply for IDD services and forward the application to the appropriate RO (See Appendix 41, I&E Applicant Information).

15.4.4.3. Tracks eligibility determinations for IDD State-funded services.

15.4.4.4. See Section 4. Eligibility and Enrollment for more detail.

15.4.5. GCAL Bed Capacity Web-Based Live Dashboard Components The Contractor will design a web-based system that at a minimum:

15.4.5.1. Permits specified referral sources (e.g., emergency rooms, agencies that refer for admissions, etc.) to upload the standardized Pre-Admission and Referral Form (PARF) for admission review to facilitate an efficient referral process and timely access to services (see Appendix 34 for sample PARF).

15.4.5.2. Provides rights-based access to DBHDD staff, referral sources, and agencies that review referrals for admission.

15.4.5.3. Permits referral sources and agencies to upload or enter information regarding bed capacity and list of Individuals on the census on as close to a real-time basis as possible.

15.4.5.4. Tracks actions taken on the system and generates activity reports (e.g., agencies that have reviewed admission information and declined, admission determinations for Individual Recipients and in the aggregate).

15.4.5.5. Time-Stamps information.

15.4.5.6. Summarizes bed capacity and census data in a “Dashboard” format that permits easy determination of available beds. (See screen shots of existing Dashboards in Appendix 23, Sample GCAL Dashboards and Reports.)

15.4.5.7. See Section 6. GCAL for more detail.

15.4.6. IDD HCBS (e.g., COMP, NOW) and State-Funded IDD Data Management Systems Web-based Components

The Contractor will design a web-based system that at a minimum:

15.4.6.1. Allows I&E managers, regional and State office personnel, SCs, and associated IDD service Providers throughout the State to input and review State and HCBS- related data.

15.4.6.2. One time upload of current and historical data and documents from the existing IDD Consumer Information System to include ISPs, assessments, eligibility documents (in word and/or PDF formats), etc. which is accessible and linked to Individual’s client record. Existing vendor’s database containing data and documents is approximately 100GB.

15.4.6.3. Allows Individuals and families to securely view his or her ISP.

15.4.6.4. Supports DBHDD’s planning list, ISPs, I&E assessments and updates, and Support Coordination monitoring.

15.4.6.5. Records, tracks, and reports the data required to effectively manage

the HCBS and State-funded IDD services provided to Individuals with IDD as well as Participants in HCBS Program.

15.4.6.6. Serves as the vehicle for monitoring the HCBS Qas and compiling compliance documentation.

15.4.6.7. Consolidates similar data currently collected in each of the six (6) regions in the new centralized database.

15.4.6.8. Hosts an electronic version of the HCBS Waiver application for services management of the planning list entails management of data about each person that includes, but is not limited to:

- 15.4.6.8.1. Demographic data (e.g., county and region of residence, name and contact information of legal representative, next of kin).
- 15.4.6.8.2. Date placed on planning list.
- 15.4.6.8.3. Name of planning list administrator.
- 15.4.6.8.4. Services requested and services receiving, how long receiving these services.
- 15.4.6.8.5. Date of next scheduled follow-up contact.
- 15.4.6.8.6. Documentation of any subsequent contacts and findings.

15.4.6.9. Captures I&E data and documentation, including transition population information. The I&E data include, but are not limited to:

- 15.4.6.9.1. Date of initial request for application for services and all previous applications and determinations. This section should also include a history of additional applications for people who have been discharged from system.
- 15.4.6.9.2. Date application mailed out.
- 15.4.6.9.3. Date “complete” application received.
- 15.4.6.9.4. Date of completion of the preliminary review.
- 15.4.6.9.5. Date the eligibility letter was sent or NOAA/due process letter was sent for denial.
- 15.4.6.9.6. Ability to assign to assessors.
- 15.4.6.9.7. Date of face-to-face contact for assessment.
- 15.4.6.9.8. Date of completion of needs assessment. 15.4.6.9.9. Notifications when assessments are completed.
- 15.4.6.9.10 Date of receipt of documentation.
- 15.4.6.9.11. Ability to input information on assessment results including documentation and notes.
- 15.4.6.9.12. Date and notes of any contacts with Individual/family.
- 15.4.6.9.13. Ability to record referral and date of referral for second review and/or testing.
- 15.4.6.9.14. Ability to enter second review and/or testing notes, documentation, dates, and results.
- 15.4.6.9.15. Notification when second referral and/or testing is complete.
- 15.4.6.9.16. Date final preliminary eligibility determined.
- 15.4.6.9.17. Date eligibility letter or NOA due process letter sent to Individual/family.
- 15.4.6.9.18. Date added to short- or long-term planning list.
- 15.4.6.9.19. Assignment of PLA if on short-term planning list.
- 15.4.6.9.20. Date of planning list letter notification.

15.4.6.9.21. Sufficient demographics are collected to align data with National Core Indicators Survey.

15.4.6.9.22. For eligibility denials, applications are archived for future reference in the event of an application resubmittal.

15.4.6.9.23. Date, comment section, and signature field in the event of an eligibility decision appeal.

15.4.6.9.24. Specific reporting capabilities for each field.

15.4.6.10. Captures LOC Determination Data

15.4.6.10.1. LOC is determined by administering the following assessments which will be housed in and/or accessed via the system:

15.4.6.10.1.1. SIS

15.4.6.10.1.2. HRST.

15.4.6.10.1.3. Social work assessment (can be no more than ninety (90) days old).

15.4.6.10.1.4. Nursing assessment completed only if the HRST is 3 or above.

15.4.6.10.1.5. Psychological assessment

15.4.6.10.1.6. Physical, occupational, speech assessments

15.4.6.10.1.7. DMA-6 or DMA-6a for initial LOC and DMA-7 for annual LOC if applicable.

15.4.6.11. The LOC data and determination will:

15.4.6.11.1. Require electronic signatures from the assessment nurse, physician, LOC nurse, SCs, and dates of coverage.

15.4.6.11.2. Auto-generate notifications of due dates on annual updates of an Individual's LOC and HRST.

15.4.6.11.3. Send system-generated automatic email alerts to the appropriate assessors if HRST and SIS assessments are at a certain level or the Individual is a certain age.

15.4.6.11.4. Generate and house electronic ISP (and revised ISP: eISP) and modifications to the ISP.

15.4.6.12. Captures planning list case management activities including: contacts, enrollment in other services, Medicaid/SSI status, etc.

15.4.6.13. Required ISP parameters include, but are not limited to:

15.4.6.13.1. Accommodation of the draft and redesigned eISP tool. (See Appendices 19, 20, and 21 for the Current ISP tool and information regarding revised ISP.)

15.4.6.13.2. The Contractor will house data from the current and newly designed eISP tool and the information in the former ISP system.

15.4.6.13.3. The new eISP will be implemented by July 1, 2016, with Individuals completing the new eISP on their birthday or when they enter into services for the first time.

15.4.6.13.4. All Individuals currently in service or entering service will have transitioned to the new eISP

format on or after by July 1, 2016 as determined by DBHDD.

15.4.6.13.5. Changes in the annual ISP are distinguishable from previous ISP language.

15.4.6.13.6. ISPs are modifiable, rather than requiring addendums.

15.4.6.13.7. Developing and housing of more than one ISP or assessment each year.

15.4.6.13.8. Automatically generating an ISP budget for each Individual and reflect any changes to the Individual's budget during the year.

15.4.6.13.9. Recording of signatures or uploads of signature pages.

15.4.6.13.10. Auto-generating email notifications to Providers and SCs when an ISP is completed and approved with relevant information from the ISP included in the email.

15.4.6.13.11. Dates for each completed step should be recorded in a manner that permits quality review (i.e., no back-dating allowed).

15.4.6.13.12. Auto-generating notification that an annual evaluation and ISP review are due.

15.4.6.13.13. The date the SC completes the ISP.

15.4.6.13.14. Indicator of whether or not the ISP is submitted timely.

15.4.6.13.15. Auto-generating email alerts to Providers indicating ISPs have been submitted, including the content of the ISP.

15.4.6.13.16. Date of any Provider correspondence as well as the content of the correspondence.

15.4.6.13.17. The Provider has five (5) days to review and discuss the ISP with the SC. If nothing happens in those five (5) days, the ISP is ready for agency QA review.

15.4.6.13.18. The capability of tracking reviews of ISPs conducted by Support Coordination agencies and the Contractor. (See Appendix 30 for the ISP QM Checklist Findings.)

15.4.6.13.19. The date the Support Coordination agency reviews the ISP for quality.

15.4.6.13.20. The date the Support Coordination agency submits to the region.

15.4.6.13.21. Indicator of whether or not the SC requests technical assistance.

15.4.6.13.22. Date of technical assistance given by RO and content.

15.4.6.13.23. The date the RO LOC nurse reviews and submitted the ISP.

15.4.6.13.24. Whether or not the RO LOC nurse review is completed timely.

15.4.6.13.25. The form completed by the RO LOC nurse.

15.4.6.13.26. Auto-generated notification for further review is noted in evaluation/ISP.

15.4.6.13.27. Date, content, and disposition of further review (e.g., form from RO physician).

15.4.6.13.28. Approval date, comments, and routing to Individuals for any Prior Authorizations required

by services (e.g., regional operations analyst).

15.4.6.13.29. The ability to create reports on any date, timely completion indicator, etc. for quality of care monitoring related to HCBS QA measures.

15.4.6.13.30. For ISP changes, if approved or not approved, a system generated alert goes to all applicable Providers, region, and Support Coordination agencies, until approved.

15.4.6.13.31. If an ISP is rejected, a notification is sent to the SC, Support Coordination Agency QA staff, and applicable Providers that it was rejected. All rejections and why ISPs are rejected are tracked until the ISP is approved.

15.4.6.13.32. Capture initial and annual assessments and evaluations of Individuals receiving services, including LOC, HRST, and SIS capture case management functions for State-funded and Medicaid-funded services and supports.

15.4.6.13.33. Interface with the HRST and SIS websites which are currently linked to Columbus Information System (CIS).

15.4.6.13.33.1. The SIS interface allows the upload of the SIS document in a PDF format.

15.4.6.13.33.2. The HRST interface allows the upload of data to populate the associated ISP.

15.4.6.14. Links the LOC, ISP, and any other assessments, and the authorization systems.

15.4.6.15. Generates and houses individual budgets associated with ISPs.

15.4.6.16. Distinguishes Individuals in directed services and self-directed services.

15.4.6.16.1. Information related to those receiving self-directed services, will include the Individual's contact information, report capabilities, analysis trending capabilities, family hiring/approvals information, an approved co-employer Provider listing, and the services they are approved to provide.

15.4.6.17. Captures program specific data, (e.g., Family Support, Supported Employment, Pre-Vocational).

15.4.6.18. Captures Support Coordination (State and Medicaid) activities (e.g., dates of visits, risk score conclusion of the visit, narrative of visit, auto-generate notifications if there is a quality-of-care concern(s). (See Appendix 31 for an example of the Support Coordination Monitoring Report.)

15.4.6.18.1. The system will automatically notify Providers of the completed monitoring report.

15.4.6.18.2. The system will notify the RO of any monitoring

report that results in a quality-of-care concern.

15.4.6.18.3. Track all monitoring outcomes that will be developed into reports by Provider, Region, or Support Coordination agency.

15.4.6.18.4. Using a standard CAP template, Providers will be able to enter information to complete a CAP to the system for DBHDD review.

15.4.6.18.5. System will prepopulate a monitoring rating based on information entered into the monitoring report.

15.4.6.19. Tracks appeals to monitor findings (e.g., Support Coordination findings) and steps/status in the appeal process in accordance with protocol (see Appendix 48, Appeals Process for Monitor Report).

15.4.6.19.1. The system will track whether or not the service Provider is satisfied or dissatisfied with the decision.

15.4.6.19.2. Whether the service Provider requests an administrative review by State or RO.

15.4.6.19.3. The system must document any changes to the score as a result of such appeals.

15.4.6.20. See Section 12, QM for more detail

15.4.7. NCB Services Authorization and Payment System Web-Based Components The Contractor will design a web-based system that at a minimum will:

15.4.7.1. Process requests for authorizations from State staff for NCB services (i.e., housing vouchers, bridge funding, and transition funding):

15.4.7.2. Permit data entry of claims, reimbursement requests, and encounters.

15.4.7.3. Provide an option for secure file transfers for electronic claim submission.

15.4.7.4. Upload electronic claims interface files in the HIPAA compliant (837) format.

15.4.7.5. Permit scanning and uploading of receipts associated with transition funding and bridge funding.

15.4.7.6. Create and maintain a list of Individuals and Recipients registered to receive NCB services.

15.4.7.7. Review all authorizations and payments for accuracy and consistency.

15.4.7.8. “Invoice” DBHDD.

15.4.7.9. Generate payments (and an associated payment record) to a landlord for housing vouchers via EFT or check, without an invoice or claim.

15.4.7.10. Allow DBHDD staff (State office or RO) to approve authorization requests for certain services that are not subject to UM/UR authorization requirements (e.g., customized goods and services for Georgia Housing Voucher/Bridge Funding). Process and pay reimbursements for services authorized and approved by DBHDD.

15.4.7.11. See Section 8. UM/UR and Section 14. Claims Payment and Claims Customer Service for more detail.

15.4.8. Authorization System Components

The Contractor will design a web-based system that at a minimum will:

15.4.8.1. Authorize services using processes consistent with the UM/UR processes and components.

15.4.8.2. System must be able to create service authorizations that are:

15.4.8.2.1. Person Centered (meaning that a single authorization for an Individual will have multiple service Providers). This is utilized for Individuals receiving HCBS and state-funded services.

15.4.8.3. Provider centric (meaning that a single authorization for an Individual will include only one Provider). This is utilized for Individuals receiving non-HCBS services.

15.4.8.4. Offer a batch submission authorization process.

15.4.8.5. Provide an electronic registration/authorization response that includes the Provider number, service location, authorization number, units/package authorized, begin and end dates, service, and billable codes.

15.4.8.6. Permit Providers to obtain information regarding the status of services for which they have been authorized, including units/packages authorized, begin and end dates, and units remaining, through a look-up function or through a response file to the Provider's batch submission request.

15.4.8.7. Provide secure viewing access to the appropriate web-based applications and reports for designated SCs, State employees, and Providers.

15.4.8.8. Permit Providers and SCs to download and print approved authorizations.

15.4.8.9. Track authorized funds by fund source (e.g., COMP, NOW, Medicaid FFS, and State-funded), services, Provider (including Individual self-direction), Individual, Recipient, and Region.

15.4.8.10. Issues an immediate on-screen notice (or documentation in a batch response file) that informs a SCA or SSCA that a clinical review is required prior to an authorization because:

15.4.8.10.1. The SCA or SSCA is registering a Recipient for a LOC for which an authorization already exists.

15.4.8.10.2. The SCA or SSCA is registering a Recipient for a LOC that cannot be simultaneously authorized with an existing service without a clinical review.

15.4.8.10.3. The SCA or SSCA is registering a Recipient for a service that otherwise requires clinical review.

15.4.8.10.4. The Recipient has been selected for a random review or targeted review (based on SCA or SSCA 's status as an outlier related to utilization patterns).

15.4.8.10.5. The SCA or SSCA has been identified as needing additional guidance or assistance in making appropriate UM/UR decisions.

15.4.8.10.6. When DBHDD has informed the Contractor to pend

all authorization requests for a specific Provider.

15.4.8.11. Have the capacity to automate edits or pend rules for manual review of specific Providers, or services.

15.4.8.12. Have the ability to link individuals' authorizations and claims paid in order to determine units utilized and remaining on each authorization.

15.4.8.13. Generate HCBS authorizations.

15.4.8.14. Provide a mechanism for Exceptional Rate requests.

15.4.8.14.1. Support uploading of information to support the request.

15.4.8.14.2. Permit review and approval by the RO or DBHDD Central Office.

15.4.8.14.3. Exceptional rate requests may be completed via the ISP.

15.4.9. The Authorization system for HCBS and State-funded IDD services will:

15.4.9.1. Fully interface with and upload datasets from external and internal DBHDD data systems, including the GAMMIS as appropriate.

15.4.9.2. Compute funding amounts based on units, unit rate, and annualized unit information for annual costs for each ISP.

15.4.9.3. Generate a summary page for each Individual that includes, at a minimum:

15.4.9.3.1. Each fiscal year allocation amount;

15.4.9.3.2. Units utilized and units remaining;

15.4.9.3.3. Medicaid number (HCBS only); and

15.4.9.3.4. Other vital information as it pertains to the authorization start and end dates.

15.4.9.4. The system will use the approved ISP to auto generate authorizations.

15.4.9.5. The system will transmit the HCBS authorizations to GAMMIS daily.

15.4.9.6. The system will receive HCBS Claims from GAMMIS.

15.4.9.7. The system will receive Recipient information through an automated process with GAMMIS.

15.4.9.8. The system will receive Medicaid Provider information.

15.4.9.9. The system will import all Medicaid Claims data from GAMMIS in a manner that allows reports on Recipient-specific reports on services utilized and paid.

15.4.9.10. See Section 8. UM/UR and Section 4. Eligibility and Enrollment for more detail.

15.4.10. PASRR LOC Review

15.4.10.1. Develop and maintain an electronic and data interface to exchange data and reports with Alliant/GMCF, DCH, and its rehabilitative services providers, and with the DBHDD. The Contractor must ensure security and confidentiality of data and compliance with applicable federal and State laws (including HIPPA Privacy Rules, 42 CFR Part 2, 45 CFR Parts 160 and 164).

15.4.10.2. Develop and maintain the capacity to accept electronic referrals from GMCF for Level II PASRR reviews.

15.4.10.3. Develop an online record system to document all requests (electronic or otherwise) for Level II PASRR reviews; to store medical record, psychological evaluation, and functional assessment information required and/or used as part of the review; and to document Level II PASRR findings.

15.4.10.4. Maintain a data tracking system to include sufficient data to meet federal and DBHDD reporting requirements, including the quality improvement, and reporting requirements defined in Appendix 28.

15.4.10.5. Work with PASRR vendor (GMCF) and DBHDD to establish a mechanism to communicate findings.

15.4.10.6. Develop an online portal for referring nursing homes to access and view the disposition of referrals.

15.4.10.7. Work with DBHDD to develop online tools to improve efficiency and quality of evaluations.

15.4.11. State-funded Claims Payment and Encounter Submission Web-Based System Components

The Contractor will design a web-based system that at a minimum will:

15.4.11.1. Permit hard copy claims or encounter submissions, including initial submissions and adjustment claims or encounters (only as an exception if electronic transmission is not possible).

15.4.11.2. Permit electronic claim or encounter submissions, including clearinghouse, electronic transmission, and direct data entry.

15.4.11.3. Conform to current and future HIPAA-compliant standards and requirements.

15.4.11.4. Maintain the receipt date for each document (e.g., claim, encounter, referral, reimbursement request, authorization, or adjustment) and track the processing time from date of receipt to final disposition.

15.4.11.5. Provide claim status information.

15.4.11.6. Allow Individuals and Recipients to access their explanation of benefits for non-Medicaid (and Medicaid) services delivered.

15.4.11.7. Offer Providers an electronic payment option via EFT.

15.4.11.8. For electronic remittance advices, the Contractor will offer Providers:

15.4.11.8.1. A secure file transfer option.

15.4.11.8.2. A secure portal for viewing remittance advices (in PDF or other report friendly format).

15.4.11.8.3. An option to download the HIPAA 835 5010 remittance file.

15.4.11.8.4. Consolidated and separate remittance advices for 1) encounters received and accepted, but not paid by the Contractor, with the value of encountered services depicted as units multiplied by rate, and 2) value of the claims paid by the Contractor on an FFS basis.

15.4.12. Provider Resource Directory

The Contractor will design a web-based system that at a minimum:

15.4.12.1. Provides an easy to use online, searchable, printable Provider Resource Directory that includes accurate and up-to-date information regarding DBHDD community Providers.

15.4.12.2. Organizes Provider information in a manner that helps Individuals make informed choices regarding Provider selection and offers choice of providers when available.

15.4.12.3. Permits searching by zip code or county to help Individuals make informed choices regarding Providers or services in their community.

15.4.12.4. Permits and allows for updates to the online Provider Resource Directory, such as a new provider, services, location, counties served, within 1 business day of DBHDD approval.

15.4.12.5. Is organized by population served (i.e., MH only, SUD only, IDD only, co-occurring MH and SUD, and co-occurring BH and IDD, crisis (other than MCT) and emergency Providers (see Section 6. GCAL) and LOC.

15.4.12.6. Includes, at a minimum, the following Provider information:

15.4.12.6.1. Demographics (e.g., name, address, phone number, and map).

15.4.12.6.2. Logistical factors including public transportation accessibility, handicapped accessibility, and additional information related to accessing services.

15.4.12.6.3. Qualifications, specialties, populations served, and languages spoken or other languages used such as American Sign Language.

15.4.12.6.4. A description of services offered and days and hours of service.

15.4.12.6.5. Additional information as requested and approved by DBHDD (e.g., QIs, performance indicators, etc.) which would assist an Individual in making an informed decision related to service providers.

15.4.12.6.6. Similar functionality currently exists at www.georgiaDDproviders.org and www.mygcal.com.

15.4.12.6.7. See Section 7. Network Management for more detail.

15.4.13. Provider Performance Profiles

The Contractor will design a web-based Provider Performance Profile system that at a minimum will:

15.4.13.1. Collect, analyze, and organize descriptive and performance-based data for Providers relative to normative data or national standards, when available.

15.4.13.2. Include Provider-specific performance data gathered from various data sets including, but not limited to: Provider profiles, QEPRs, FUTACs, BH audits, Provider compliance data from DBHDD reviews, outcome data, and other QIs that comprise the Provider Performance Profile.

15.4.13.3. Include QM data elements (see Section 12. QM) including, but not limited to:

15.4.13.3.1. Compliance scores for HCBS requirements and QAs.

15.4.13.3.2. Prequalification, verification, and Continued Qualification Requirements data.

15.4.13.3.3. Complaint and satisfaction data.

15.4.13.3.4. Access standard compliance.

15.4.13.3.5. Suspensions or other disciplinary actions taken.

15.4.13.3.6. Incidents.

15.4.14.5.4. Other indicators as requested, (e.g., quality council recommendations regarding what to measure).

15.4.13.4. Offer an online data entry or upload of providers' self-reported performance indicators as identified by DBHDD.

15.4.13.5. Provider Performance Profiles will:

15.4.13.5.1. Be easy to read and understand, consistent with Individuals at a fifth (5^{th}) grade reading level.

15.4.13.5.2. Provide an explanation of the meaning of each data element and a description of how the data may be interpreted.

15.4.13.5.3. Limit viewing capability based on user category (e.g., public, DBHDD, Provider, Contractor, UM/UR, GCAL, Individual, family member/caretaker).

15.4.13.5.4. Consolidate information from various sources or functions within the scope of this RFP.

15.4.13.6. IDD QI council portal will:

15.4.13.6.1. Provide a public area where information can be posted and viewed.

15.4.13.6.2. Provide a secure access area where private information can be shared, a forum to interact and communicate between users, and a place to share information which may contain protected health information (PHI).

15.4.14.5.5. See existing website (http://www.dfmc-georgia.org/).

15.4.13.7. IDD Human Rights Portal

15.4.13.7.1. Provides both public and private/secure areas where information can be shared.

15.4.13.7.2. Provide a public area where information can be posted and viewed.

15.4.13.7.3. Provide a secure access area where private information can be shared, a forum to interact and communicate between users, and a place to share information which may contain protected health information (PHI).

15.4.14.5.6. See existing website (http://www.dfmc-georgia.org/).

15.4.14. The Contractor will develop and maintain the following applications:

15.4.14.1. In accordance with Section 12. QM of this RFP, the Contractor will establish and maintain a critical incident application that is capable of collecting, storing, and producing meaningful information for the purposes of critical incident tracking and reporting. The critical incident system will:

15.4.14.1.1. Receive and import critical incident data from DBHDD's critical incident IS on a routine basis.

15.4.14.1.2. Include reporting that provides information in the form of standard reports, and threshold reports or alerts, which would trigger Contractor intervention (e.g., a Provider incurs a pre-specified number of incidents).

15.4.14.2. In accordance with the Section 10, Complaints and Grievances contract, the Contractor will establish and maintain an application to track Complaints and Appeals, with resolution status, and reporting capabilities.

15.4.14.3. In accordance with the Section 4. Eligibility and Enrollment and Section 8. UM/UR of this RFP, the Contractor will develop an application that receives, tracks, and stores the following information, at a minimum, that is used by I&E and UM/UR staff for BH and IDD services:

15.4.14.3.1. Assessment tool results (e.g., LOC assessment, functional assessment).

15.4.14.3.2. Criteria applied (e.g., program criteria, Medical Necessity).

15.4.14.3.3. Practice guidelines used (e.g., Major Depression, Schizophrenia).

15.4.14.3.4. Authorization determinations and NOAA.

15.4.14.3.5. Appeals.

15.4.14.3.6. Peer review.

15.4.14.4. In accordance with the Section 12. QM of this RFP, the Contractor will establish and maintain an application that supports all quality monitoring, reporting and fiscal accountability monitoring for all Medicaid and State-funded programs and associated I&E and POC processes. Application features include, but are not limited to:

15.4.14.4.1. Limited user levels for information input and review.

15.4.14.4.2. Individual's name and Medicaid number (as it appears on all official documents) to reduce error.

15.4.14.4.3. Mass mail-out feature for Individuals active in the IS.

15.4.14.4.4. Initial enrollment data.

15.4.14.5.7. Capacity to store, search, and analyze information regarding the Individual's service history and funding including Waiver funding, State funding, facility admissions and discharges, planning list information, PLA services, current Providers, crisis plans, assessment results, ISPs, and other relevant information.

15.4.14.5. In accordance with the Section 8 UM/UR of this RFP, the Contractor will establish and maintain a Provider profile

application. Application features include, but are not limited to:

15.4.14.5.1. Demographic information.

15.4.14.5.2. Population served, including volume.

15.4.14.5.3. Utilization across Individuals and Recipients by LOC (if applicable) and service type including average length of stay, average number of services, average cost of services per Individual/Recipient, etc.

15.4.14.5.4. Number of individual/Recipient outliers served.

15.4.14.5.5. Denial rate.

15.4.15.5.6 Percentage utilization of Authorized Services.

15.5 Telephone System

15.5.1. Establish and maintain a telephone system that supports the following functions, including but not limited to:

15.5.1.1. A single line for (GCAL) crisis and access calls, in compliance with the requirements in the GCAL Section 6.

15.5.1.2. A private line which provides a direct connection between GCAL and crisis and inpatient services Providers (e.g., emergency rooms, CSUs, MCTs, State hospitals) in order to coordinate referrals between parties.

15.5.1.3. A separate customer service line that is in compliance with the requirements in Section 14, Claims.

15.5.1.3.1. UM and review processes in compliance with the requirements in the Section 8, UM/UR.

15.5.1.3.2. Responding to Individual, Recipient, family member/caretaker, and provider calls, text or chats including information requests and Complaint calls in compliance with the requirements in the Complaints section.

15.5.1.3.3. Responding to Provider calls including questions regarding prequalification and qualification verification, audits, and audit feedback, and other Provider questions.

15.5.1.4. Telephone conferencing.

15.5.1.5. ACD software

15.5.1.6. Messages addressing system downtime or other system-wide concerns.

15.5.1.7. See Section 6. GCAL for more detail.

15.6 Required Data Elements and Parameters

15.6.1. The Contractor will include all of the data elements necessary to effectively perform the functions and requirements associated with this Contract.

15.6.2. Required data elements include (see Sections 16, Data Management and Reporting and Section 18. Client Records for more detail), but are not limited to:

15.6.2.1. Individual and Recipient demographic data (i.e., socio-demographic and contact information; unique client ID, ISP, etc.).
15.6.2.2. Assessment data (i.e., diagnoses, level of functioning scores, assessments, LOC assessments, substance use screening, etc.).
15.6.2.3. UM/UR data (eligibility data, denials, appeals, NOAAs, authorizations, profiles).
15.6.2.4. Service encounter data (i.e., date, type, duration, Recipient, Provider).
15.6.2.5. Episode data (i.e., service program, unique episode ID, date of first contact, date of admission, date of last contact, date of discharge, etc.).
15.6.2.6. Programmatic data (i.e., service population and eligibility criteria, payer source, fee schedules, etc.).
15.6.2.7. Claim data (i.e., Individual, Recipient, Provider, date, type duration, fee, etc.).
15.6.2.8. Provider data (i.e., credentials, Provider profiles, Provider Performance Profiles, open authorizations, Provider agency, name, unique provider ID, approved services).
15.6.2.9. Provider directory data.
15.6.2.10. QM data (i.e., QI, data elements for measuring HCBS assurances, PMs and PGs, training offered, competency testing, and attendance).

15.6.3. Provider Data and Provider-related documentation requirements include, but are not limited to:
15.6.3.1. Input and maintenance of Provider demographics including, but not limited to: Provider type, specialties, service locations, applicable regulatory licenses, services provided, accreditation, agency's insurance coverage, group/Individual provider relationships, facility linkages, Provider's insurance panel participation, type of contractual agreement with DBHDD (contract, letter of agreement, etc.),

contract funding amounts by service and disability type, and enrollment effective dates and status.
15.6.3.2. Input and maintenance of Provider's "key staff" information including, but not limited to: staff credentials professional licenses, certification numbers and dates, NPI numbers, and unique identifiers for direct care workers not required to obtain NPI numbers.
15.6.3.3. Maintenance of community-based Providers' demographics, including peer and family-run organizations, their qualifications, location, services, enrollment effective dates, and status.
15.6.3.4. Collection of federal employer identification number or Social Security numbers for atypical providers in HIPAA compliant formats.
15.6.3.5. Crosswalks of any internal system provider ID numbers to State recognized ID numbers (e.g., State generated IDs, Medicaid IDs,) for use in communication with the State.
15.6.3.6. Provider fee schedules, fee schedule history and rate changes by applicable dates.
15.6.3.7. Provider characteristics used during Provider search activities

and as part of the Provider Resource Directory (e.g., location, specialty).

15.6.3.8. Provider performance data including, but not limited to: audit outcomes, quality information, UM trends, number and type of complaints and other data necessary to produce Provider profile reports and Provider Performance Profiles.

15.6.3.9. Coordination, communication, and synchronization of Provider data with the DBHDD's Provider data.

15.6.3.10. Collection and storage of hardcopy and electronic submission of referral and authorization support documents, Claim inquiry forms, and Claim adjustment submissions.

15.6.3.11. Collection and storage of hardcopy and electronic documents related to provider Letters of Intent and applications to include but not limited to the agency's submission of these documents, corrections, and subsequent communications.

15.6.3.12. Collection and storage of Medicaid authorization data with unique authorization numbers compatible with GAMMIS.

15.7 Data Exchange Requirements

The Contractor's data exchange processes and parameters will include, but are not limited to:

15.7.1. Receiving and maintaining eligibility information.

15.7.2. Loading the eligibility data within one (1) business day of receipt.

15.7.3. Capturing Individual and Recipient third-party liability information.

15.7.4. Generating and reporting error status on files transmitted.

15.7.5. Receiving and maintaining State provider files with Provider demographics, fee schedules, and a list of reimbursable services.

15.7.6. Daily, electronic transferring of authorization information to the GAMMIS vendor (currently, HP) in the specified format.

15.7.7. Receiving claims data files from GAMMIS for the Contractor to conduct analytics and reporting including, but not limited to:

15.7.7.1. Analyzing service trends.

15.7.7.2. Preparing service utilization reports.

15.7.7.3. Identifying patterns of service utilization and outcomes for Medicaid Individuals and Recipients receiving high volumes of service.

15.7.7.4. Receiving error reports for authorization issues and corrections regarding file transmissions.

15.7.7.5. Conducting analysis of inpatient, emergency room, and pharmacy claims.

15.7.8. Receiving data files from the State's critical incident system for analysis and reporting.

15.7.9. Electronically exchanging data files with trading partners (e.g., SAMHSA,

Center for Substance Abused Treatment, or other vendors) in the specified format.

15.7.10. Conducting proprietary data exchanges (e.g., HCBS LOC, ISP, PMs) data and forms.

15.7.11. Electronic data exchange for DBHDD financial systems (e.g., PeopleSoft, Uniform Accounting System) with data regarding Contractor's payments to Providers. File will be in an acceptable file format for the specific system.

15.7.12. One time upload of current and historical data and documents from the existing IDD CIS to include ISPs, assessments, eligibility documents (in word and/or PDF formats), etc.

15.7.13. Electronically exchange data files with ALLIANT/GMCF for PASRR LOC referrals and findings in a format approved by DBHDD and ALLIANT/GMCF.

15.8 IS Documentation, Security, Disaster Recovery, and Business Continuity

15.8.1. The Contractor will comply with all federal and State laws, rules, and regulations regarding system security and privacy.

15.8.1.1. Applications, operating software, middleware, and networking hardware and software will conform to applicable data security standards and specifications set by HIPAA and other federal regulations.

15.8.1.2. The Contractor will inform DBHDD of any reportable violation of PHI protections within twenty-four (24) hours of the known violation.

15.8.1.3. No later than thirty (30) days after the contract effective date, the Contractor will submit to DBHDD for approval an Information Systems Plan.

15.8.1.4. The Contractor's IS Plan will include the following components:

15.8.1.4.1. Project Plan (e.g., implementation schedule, timelines, tasks, and milestones required for implementing the various components of the proposed information system) which addresses:

15.8.1.4.1.1. Hardware, software, and facilities

15.8.1.4.1.2. System / Technical Documents

15.8.1.4.1.3. System Interfaces

15.8.1.4.1.4. Data conversion/transfer (data and documents from previous vendors)

15.8.1.4.1.5. Security and Privacy

15.8.1.4.1.6. Testing Plan

15.8.1.4.1.7. User Guides / Manuals

15.8.2. The Contractor will implement testing processes and maintain testing results, with each attribute tested, prior to implementation of a new system or system component.

15.8.3. For each of the functional components, the documentation will address, where

applicable:

15.8.3.1. Program narratives;
15.8.3.2. Processing flow diagrams;
15.8.3.3. Forms;
15.8.3.4. Screen shots;
15.8.3.5. Reports;
15.8.3.6. Files;
15.8.3.7. Detailed logic, such as Provider lookup capabilities;
15.8.3.8. System edits;
15.8.3.9. Operational instructions; and
15.8.3.10. Project signoff.

15.8.4. The Contractor will track system downtime including the system name, beginning time of downtime, length of downtime, time of return to function, date, and reason for downtime. (See Section 13. PMs and Guarantees for more information.)

15.8.5. Within thirty (30) days of initial IS implementation and any subsequent changes to the IS, the Contractor will document system information including, but not limited to:

15.8.5.1. A system introduction.
15.8.5.2. Program overviews.
15.8.5.3. Operating environment.
15.8.5.4. External interfaces.
15.8.5.5. Data element dictionary.

15.8.6. System Physical Security The Contractor will:

15.8.6.1. Develop and implement internal policies and procedures for system physical security.
15.8.6.2. Document HIPAA security testing and validation compliance.
15.8.6.3. Restrict system access (e.g., log in requirements, password management and recovery, role-based access, etc.).
15.8.6.4. Implement role-based access control to data and reports including, but not limited to job function or role, organization, DBHDD RO, DBHDD Central Office, report type (e.g., operational, business, federally mandated), and public reports.

15.8.7. Disaster recovery plan will include, at a minimum, planning and training for:

15.8.7.1. Electronic or telephonic failure at the Contractor's main place of business, the GCAL, or internet connection for Providers that deliver crisis services.
15.8.7.2. Complete loss of use of the Contractor's main site.
15.8.7.3. Loss of primary electronic information systems including computer systems and records.
15.8.7.4. Strategies to communicate with the State in the event of a business disruption.
15.8.7.5. A listing of key Contractor priorities, key factors that could cause disruption and under what timelines Contractor will be able to resume critical customer services.
15.8.7.6. Specific timelines for resumption of services, including the percentage of recovery at certain hours and key actions required to meet the timelines.
15.8.7.7. Periodic testing capabilities performed at least once a year.

15.8.7.8. Permanent archiving of all major files for a period of no less than seven (7) years.

15.8.7.9. Backup/restore capabilities with key processes that must be restored in the timelines that follow:

15.8.7.9.1. GCAL: twenty-four (24) hours or less.

15.8.7.9.2. Eligibility verification: twenty-four (24) hours.

15.8.7.9.3. Enrollment update process: twenty-four (24) hours.

15.8.7.9.4. Prior authorization/referral processing: twenty-four (24) hours.

15.8.7.9.5. Claims/encounter processing: seventy-two (72) hours.

15.8.7.9.6. Encounter submissions to State: one (1) week.

15.8.7.9.7. Other functions: two (2) weeks.

15.8.7.10. System Back-Up Requirements.

The Contractor will have data backup processes (e.g., daily, weekly, and monthly) that incorporate the following characteristics:

a. Database data replication and synchronization across multiple physical servers.
b. Full duplication of the production database for failover and backup in the event of a database corruption or failure.
c. An environment that provides the ability to recover immediately and normally, using the standby/backup database.
d. The ability to perform backups and restore function in a full, incremental, and differential manner.
e. Firewall security.

15.9 The Contractor will provide DBHDD with all relevant IS-related reports as required in this section and Appendix 26, Deliverables and Reports Matrix.

15.10 The Contractor will report to DBHDD regarding all relevant IS-related PMs in this section, Performance Guarantees Section 13 Contractor Performance Measures and Guarantees and Appendix 18, PMs.

16 Data Management and Reporting

16.1 General Requirements

16.1.1. The Contractor will have IS capable of storing and analyzing data and creating reports necessary to the efficient and effective administration of DBHDD programs and services, including, but not limited to:

16.1.1.1. Administrative services;
16.1.1.2. Compliance;
16.1.1.3. Eligibility and enrollment;
16.1.1.4. Intake and Evaluation
16.1.1.5. Covered benefits;
16.1.1.6. GCAL services;

16.1.1.7. UM/UR;
16.1.1.8. Care Coordination;
16.1.1.9. QM, including the HCBS assurances;
16.1.1.10. Performance measurement;
16.1.1.11. Network management;
16.1.1.12. Complaints, grievances, appeals, and Fair Hearings;
16.1.1.13. Client records;
16.1.1.14. Claims and encounter management;
16.1.1.15. Claims customer service;
16.1.1.16. IS; and
16.1.1.17. Finance as described in the respective Sections herein.

16.1.2. The Contractor's data management system will be capable of interfacing with the DBHDDs data warehouse for the purpose of creating reports. In coordination with DBHDD, specific data files, formats, and schedule will be determined. At a minimum, data will include demographics, authorizations, Claims and Encounters, assessments, and other programmatic information.

16.1.3. The Contractor will comply with all reporting requirements contained in this Contract and future reporting requirements resulting from changes in state and federal reporting requirements (e.g., Healthcare Reform Initiatives, SAMHSA requirements, HCBS).

16.1.4. The Contractor will develop and maintain a secure internet-based portal or application available to identified DBHDD for generating standard, ad hoc reports, and data files. Standard reports required for this Contract are contained in Appendix 26, Deliverables and Reports Matrix.

16.1.5. The contractor will develop and maintain a secure internet-based portal or application available to identified DBHDD "Power Users" who may have direct access to query data, generate reports, and/or data files. This may be accomplished through a decision support or business intelligence tool.

16.2 Reporting Requirements

16.2.1. The Contractor will comply with the following reporting requirements:
16.2.1.1. The Contractor will furnish all standard reports listed in Appendix 26, Deliverables and Reports Matrix in formats prescribed by the State (e.g., Excel, CSV, PDF, data file, etc.), within the time frames listed in Appendix 26, Deliverables and Reports Matrix. Visual reports containing graphs, charts, or Dashboards are preferred when possible. Upon request by DBHDD, the Contractor will export data to Excel or CSV files with appropriate rights to allow sorting and filtering based on the data values in the report.
16.2.1.2. Whenever the due date for a report falls on a day other than a business day, such due date will be the next business day.
16.2.1.3. An official representative of the Contractor will request in writing an extension for submission when it is apparent that the submission date for a report will not be met.
16.2.1.3.1. This request must be received by DBHDD no later

than one (1) business day before the scheduled due date of the report. DBHDD retains the right to approve or deny the request for extension.

16.2.1.4. DBHDD, through designated positions(s) or identified person(s), will have the right to create additional reporting requirements when required by business need or applicable federal or State laws and regulations, without additional compensation to Contractor, unless the Contractor demonstrates that to meet such requirements, there must be a modification to the functional design of the IS, which will result in additional and substantial costs to the Contractor.

16.2.1.5. The Contractor will have policies and procedures that address the integrity of the data maintained within the IS, to ensure the quality and integrity of the reports produced.

16.2.1.5.1. The Contractor will complete periodic data integrity audits as determined by the State.

16.2.1.5.2. The Contractor will perform periodic random audits of information/data submitted by Providers to the Contractor and as requested by the State.

16.2.1.6. Reports provided by the Contactor will include national, regional, or other benchmarks to provide context for the results reported, when applicable. In addition, performance history will be provided for the previous twelve (12) months in an annual, quarterly, or monthly format, as requested by the State.

16.2.1.7. For each report provided to DBHDD, results will be aggregated to represent statewide, regional, Provider-specific, funding source, or other data breakouts, as applicable and requested by DBHDD.

16.2.1.8. The Contractor will identify a contact responsible for the coordination of the transmission of reports, correction of errors associated with the reports, as well as the resolution of any follow-up questions regarding the report.

16.2.1.9. The Contractor will advise the State, within one (1) business day, after the Contractor identifies an error in a line item of a report and submit a corrected report within three (3) business days of becoming aware of the error. The Contractor will specify on the corrected report the element changed, the cause of the error and the procedures that the Contractor will implement to monitor and prevent future occurrences. (See Section 13. PMs and Guarantees).

16.3 Performance and Programmatic Dashboard(s)

16.3.1. The Contractor will develop interactive internet-based Dashboard(s) that provide visual displays of key Contractor and system PMs relative to goals and benchmarks.

16.3.2. The Contractor will develop interactive internet-based Dashboard(s) that provide visual displays of key programmatic information (e.g., individuals served, expenditures, Provider Network).

16.3.3. The Dashboard(s) will be compatible with modern mobile technology (e.g., smart phones, tablets, iPads) so that they are accessible twenty-four/seven (24/7) via mobile technology for identified DBHDD staff.

16.3.4. The Dashboards(s) will include security features such as passwords and user level viewing restrictions. Dashboards may be available to the public or have limited access, depending on specific information depicted (e.g., DBHDD executive management, programmatic staff) as determined by DBHDD.

17 Financial Management

17.1 General Requirements

17.1.1. The Contractor will develop and maintain internal controls and systems to separately accept and account for funds provided by DBHDD to pay Providers for services rendered and revenue paid by DBHDD to the Contractor for Contract administration using EFT protocols.

17.2 Financial Reporting and Documentation The Contractor will:

17.2.1. Incur an annual financial audit in accordance with applicable State and federal requirements, for any expenditure of State-provided funds, which includes Medicaid, grant or other funds, made by the Contractor to be completed within 180 days of the end of the Contractor's fiscal year.
- 17.2.1.1. The audit will include management letters and audit recommendations.
- 17.2.1.2. All audit reports and documentation will be available to the State upon request.
- 17.2.1.3. The Contractor will comply with federal and State single audit standards, as applicable.

17.2.2. Maintain a financial reporting system capable of separately reporting revenue and expenses related to the performance of this Contract.
- 17.2.2.1. The financial reporting system will have the capabilities to report expenditures by program type, by Provider, by Recipient, or by Individual at the funding level source as directed by the State.
- 17.2.2.2. Financial reports will be accurate, complete, and timely.

17.2.3. Maintain books, records, documents, program, Individual and Recipient service records, and other evidence of its accounting procedures and practices, which sufficiently and properly reflect all costs of any nature incurred in the performance of the Contract.

17.2.4. At all reasonable times, financial records and reports will be subject to monitoring, inspection, review, or audit by authorized employees or agents of the State or, where applicable, federal agencies.

17.2.5. The Contractor will retain all such records concerning the Contract in

accordance with the State's record retention policies and State and federal law.

17.3 Financial Policies and Procedures

17.3.1. The Contractor will have internal policies and procedures that at a minimum, address the following:

17.3.1.1. Identification, pursuit and recording of all third-party resources.

17.3.1.2. Financial accountability systems in place that include, at a minimum, the components listed in Appendix I of the IDD HCBS Waivers in Appendices 2 and 3.

17.3.1.3. Aid DBHDD in managing available State funds in order to continuously provide services through the contract year.

17.4 Contractor Payments DBHDD will:

17.4.1. Provide funds that are subject to the terms and conditions of this Contract.

17.4.2. Pay the Contractor, provided the Contractor's performance is in compliance with the terms and conditions of the Contract.

17.4.3. Make payments to the Contractor for the administrative component of the contract in twelve
(12) monthly installments throughout the Contract year.

17.4.4. Reimburse the Contractor for payments made to providers.

17.4.4.1. The Contractor will be required to submit reports to DBHDD monthly, at a minimum, delineating payments made to Providers.

17.4.4.2. DBHDD will utilize reports submitted by the Contractor as a basis for reimbursement to the Contractor for Provider reimbursements. In addition, Contractor will provide data file(s) to validate and summarize Provider payments compatible with DBHDD's accounting system (e.g., PeopleSoft).

17.4.5. Work with the Contractor to manage available funds to continuously deliver services throughout the entire Contract year.

17.4.6. Adjust funding allocations during the Contract period if necessary based upon funding availability.

17.4.7. Immediately recoup any payments to the Contractor that were determined to be based on erroneous or fraudulent reports or the Contractor's failure to report.

17.4.8. Immediately require recoupment of any payments to a Provider that were determined to be based on erroneous or fraudulent reports or the Provider's failure to report.

17.5 The Contractor will provide DBHDD with all relevant Financial Reports as required in

Appendix 26.

17.6 The Contractor will report to DBHDD regarding all relevant Financial PMs in Appendix 18.

18 Client Records

18.1 General Requirements

The Contractor will collect or provide viewing access to all data elements necessary to:

18.1.1. Effectively manage and improve the quality of administrative services performed by the Contractor.

18.1.2. Evaluate the quality of care delivered by Providers. See Section 8 (UM/UR), Section 12 (QM), and Section 15 (IS and Data Exchange) for more information regarding required data elements. See Appendix 17a-f for data elements currently collected related to MICP.

18.1.3. Deliver effective GCAL services as delineated in Section 6. GCAL.

18.1.4. Meet all reporting requirements. See Section 16. Data Management and Reporting for more information regarding required client record data elements for reports.

18.1.5. Meet all performance measurement and PG requirements.

18.1.6. Comply with all Contract requirements.

18.1.7. The Contractor will comply with all federal and State laws, rules, regulations, and standards regarding the establishment, creation, receipt, transmission, privacy, confidentiality, release, storage, maintenance, and retention/disposition of client information (e.g., authorizations, claims/encounters, ISPs, etc.) and other administrative records.

18.2 UM/UR Records

18.2.1. The Contractor will collect the data necessary to conduct the UM/UR functions required by this Contract (see Section 8 (UM/UR) for more information). At a minimum, those data elements include:

- 18.2.1.1. Individual and Recipient demographics (e.g., Name, CID, Medicaid ID number, Social Security number, age, date of birth, gender, and address).
- 18.2.1.2. Date and time of the request for eligibility verification, registration, Authorization (i.e., Prior Authorization, Concurrent Review Authorization, and other Authorizations) occurred.
- 18.2.1.3. Type of service requested (e.g., inpatient psychiatric, PRTF).
- 18.2.1.4. Type of service authorized or denied, including procedure codes and NOAA, if applicable.
- 18.2.1.5. Number of visits, days, or units of service requested.

18.2.1.6. Number of visits, days, units of service, or dollar limit authorized.
18.2.1.7. Start and stop dates of Authorization.
18.2.1.8. Authorization number, date, and time.
18.2.1.9. Diagnostic information (e.g., ICD-9, ICD-10, DSM-V).
18.2.1.10. Functional assessment information and scores (e.g., Child and Adolescent Needs and Strengths Assessment, Adult Needs and Strengths Assessment, SIS, HRST).
18.2.1.11. Authorized service Provider name and ID number.
18.2.1.12. LOC (DMA-6 or DMA 7).
18.2.1.13. The program (e.g., Medicaid or non-Medicaid) under which coverage is provided for each service request, which will in turn indicate whether or not a NOA or denial notice is required to be sent for an adverse decision.
18.2.1.14. The funding source of Authorized services (e.g., name of block grant, special program, or FFS Medicaid).
18.2.1.15. An indicator of potential Medicaid eligibility for those who are not enrolled.
18.2.1.16. Priority population indicators (e.g., ADA Settlement Agreement target population, pregnancy, IV drug use, discharging from hospital, prison, or jail, etc.).
18.2.1.17. An indicator of legal status (e.g., involvement and/or mandated activity by type, related to the service Authorization in question).
18.2.1.18. Other individual-specific outcome information that is currently collected from BH Providers via datasheets and/or entering information into a web-portal and through the MICP during the Authorization process (e.g., data for Qis, KPIs, PMs, NOMS, TEDS, etc.).
18.2.1.19. For Intensive BH Services, the Contractor will also collect, at a minimum the following:
18.2.1.19.1. Clinical and functional assessment information, and any necessary supporting documents, which justify the service Authorization specific to the admission criteria and LOC for specified service.

18.2.2. The Contractor will maintain internal records of all UM/UR decisions, Recipient clinical status, and service utilization in a manner consistent with Contractor policy and procedures, as approved by DBHDD including, but not limited to:
18.2.2.1. The name and credentials of the Individual that authorized, denied, or conducted Peer Review for each requested service.
18.2.2.2. The status of any requested documentation.
18.2.2.3. The Recipient's presenting symptoms, symptom history, and treatment/service history.
18.2.2.4. Clinical review notes.
18.2.2.5. Notes from discussions with other medical professionals employed by or contracted by the Contractor.
18.2.2.6. Notes from discussions with other care coordinators or medical professionals from other agencies, facilities, or Providers.
18.2.2.7. At a minimum, a citation indicating the review criteria specific to service/LOC requirements for denials of requested

services/Authorization.

18.2.2.8. Copies of any relevant correspondence, including NOAA.

18.2.2.9. Appeal information, if applicable.

18.2.2.10. Any other information or call tracking related to a Recipient's care.

18.3 QM Records

The Contractor will collect and retain sufficient information for the QM database to be maintained. At a minimum, the Contractor will collect the following information:

18.3.1. Assessment data, including:

18.3.1.1. Assessment date.

18.3.1.2. Reviewer name, credentials, and organization. Note that the data collected must be sufficient for the contractor to compare with providers on the plan of care. This information is used to determine that the assessor and care manager are not providers of HCBS services or individuals who have an interest in or are employed by a provider of HCBS. The State may make an exception due to access issues in a geographic area. In those exceptions, the Contractor must collect information regarding name, credentials, and organization sufficient to permit the Contractor and State to monitor conflict of interest standards.

18.3.1.3. Indication of whether the assessment is an initial assessment or a reassessment.

18.3.1.4. The criteria utilized for assessment determinations.

18.3.1.5. The Individual's strengths and goals using a person-centered approach, emphasizing those strengths that could be mobilized to meet the Individual's goals.

18.3.1.6. The Individual's service needs based on a comprehensive bio-psychosocial assessment, inclusive of MH, substance use, physical health, IDD conditions or disabilities, and other significant co-morbidities.

18.3.1.7. Risk assessment sufficient to drive completion of the assessment domains.

18.3.2. Individual Service Plan Data

The Contractor will collect or have viewing access to the following information:

18.3.2.1. Outline of the goals of the Individual, framed in the Individual's own words.

18.3.2.2. Natural supports available to the Individual.

18.3.2.3. Person-Centered Planning and/or recovery—oriented principles.

18.3.2.4. The clinical, medical, developmental, social, and cultural (including spiritual, if pertinent) goals and needs of the Individual that were identified in the assessment.

18.3.2.5. Strategies to address the health and safety risks indicated in the assessment.

18.3.2.6. A crisis plan, including the person's preferences for accessing natural supports, use of specific treatments, facilities, and treatment Providers.

18.3.2.7. A back up plan, if applicable, in case a Provider does not come to the Individual's home on the assigned day.
18.3.2.8. A list of all identified needs from the assessment that are a current priority of treatment.
18.3.2.9. A list of all goals of the Individual as indicated in the assessment.
18.3.2.10. The type, amount, duration, and frequency of services the Individual will receive.
18.3.2.11. The date and signature of the Individual.
18.3.2.12. The names and roles of the ISP development team, including the Individual, the SC, the case manager, and others requested by the Individual, such as family/caregiver, other natural supports, if pertinent, and Providers.
18.3.2.13. Confirmation that the ISP was developed (or information obtained) at times and locations of convenience for the Individual and from people important to the Individual.
18.3.2.14. ISP updates when a change in an Individual's needs is identified after development of an initial service plan, no less often than annually.

18.4 QM and Performance Measurement Data Collection Elements

18.4.1. The Contractor will collect sufficient data for IDD QM activities, including QEPRs, QUTACs, and other Provider audits to evaluate performance related to the IDD, HCBS and State-Funded Qas; and other PMs including, but not limited to data that confirms:
18.4.1.1. Services are provided in a timely manner.
18.4.1.2. Services are consistent with the ISP and delivered to Individuals new to the Waivers within forty-five (45) days of ISP approval.
18.4.1.3. The Individual knows that they have a choice of Providers and that assistance was provided to let the Individual know what services are available, and which Providers are available to provide those services.
18.4.1.4. There is evidence of freedom of choice that specifies choice between institutional and Community based services and among services and Providers that the Individual completed and signed.
18.4.1.5. The Individual received and documented receipt of information about State Fair Hearing rights.
18.4.1.6. The Individual received information about how to file complaints regarding quality of care.
18.4.1.7. The Individual received information about how to report suspected abuse, neglect, or exploitation.
18.4.1.8. The Individual received information on their rights and how to file a complaint or grievance if the Individual believes those rights are violated.
18.4.1.9. Other HCBS and State Funded Data Elements
18.4.1.9.1. QEPR data including Individual Interview Instrument, ISP QA Checklist, PRRs, administrative record review (i.e., review of policy and procedure, staff qualifications, and training), staff/Provider interview results, onsite observations of residential or day programs, and measures

of family satisfaction using the NCI Family/Guardian Survey or the Adult Family Survey.

18.4.2. The Contractor will collect sufficient data for BH QM activities including TEDS reporting; NOMS reporting; PMs and QM indicators.

18.5 GCAL Records. The Contractor will collect sufficient data to document and evaluate the quality of the crisis and access services delivered through GCAL. Data elements include, but are not limited to:

18.5.1. BH and IDD call records, which include the following information that is collected whenever possible. If the call is urgent or otherwise warrants immediate action, and the collection of information hinders the success of the referral, all of the information below is not required, but desired.

18.5.1.1. Registration number.
18.5.1.2. The nature of the crisis or emergency, if applicable, or the nature of the referral being sought.
18.5.1.3. Contact information, location, and current environment.
18.5.1.4. Individual-specific information if called is someone other than the person seeking assistance/in crisis.
18.5.1.5. The presenting symptoms and service history, if applicable, of the person seeking assistance/in crisis.
18.5.1.6. Assessment of danger to self or others and history of self-or other-directed harm/violence.
18.5.1.7. Assessment of current and past alcohol and/ or substance use, including any withdrawal experienced.
18.5.1.8. Suicide screening components.
18.5.1.9. Other clinically relevant information.
18.5.1.10. Notes from discussions with other professionals both employed by and/or subcontracted with the Contractor.
18.5.1.11. Notes from discussions with external Providers or professionals (e.g., referral sources, mobile crisis, etc.).
18.5.1.12. Determination of urgency (e.g., crisis, emergent, urgent, or routine).
18.5.1.13. Resources dispatched and/or referrals made including acceptance and denials.
18.5.1.14. Form of insurance or third-party coverage (e.g., Medicaid, Medicaid CMO, name of insurance company, etc.).
18.5.1.15. Start and end time of call and related calls, including elapsed time from start of call to disposition.
18.5.1.16. Final disposition/status.
18.5.1.17. Follow-up contacts, if applicable.
18.5.1.18. Any other information or call tracking related to the call.

18.5.2. For calls, text or chat that result in a mobile crisis dispatch and monitoring, data will include, but is not limited to, the following:

18.5.2.1. Length of time required for the triage to result in decision to dispatch mobile crisis.
18.5.2.2. The length of time between dispatch and the arrival of the MCT on scene.
18.5.2.3. The length of time from the arrival of the MCT and completion of the intervention.
18.5.2.4. Information regarding the identity of the MCT dispatched (e.g., vendor, clinician name or ID, region, zone).
18.5.2.5. Information regarding the source of the call, including physical address (including county) of residence and of the location of the

crisis, the referral source, location type, dispatch level.

18.5.2.6. Information regarding the disposition including, but not limited to the outcome of the mobile crisis response, whether an involuntary evaluation (i.e., 1013) was ordered and whether that was initiated by the MCT or another provider (e.g., emergency room physician), and/or whether an involuntary evaluation had been ordered but was rescinded after MCT involvement.

18.5.2.7. Information regarding any dispatches that did not result in a completed contact with individual (e.g., no show, canceled, etc.).

18.6 Record Retention

18.6.1. Financial, statistical, and all other records and supporting documents pertinent to a Contract award will be retained for a period of six (6) years from the date of submission of the final expenditure report or, for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report.

18.6.1.1. If any litigation, claim, financial management review, or audit is started before the expiration of the (6) six-year period, the records shall be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken.

18.6.1.2. Records for real property and equipment acquired with federal funds shall be retained for (6) six years after final disposition.

18.6.2. Other Record Requirements

The Contractor will:

18.6.2.1. Develop written internal policies and procedures that regulate access to Beneficiary, Individual, and Recipient records consistent with 42 CFR §2.16.

18.6.2.2. Retain records in accordance with 42 CFR Part 2, HIPAA and other federal and State laws, rules and regulations relating to the privacy and security of mental health, IDD, and substance use records.

18.6.2.3. The State, DBHDD, the US Comptroller General, and any of their duly authorized representatives, will have access to any books, documents, papers, and records of the Contractor, which are directly pertinent to a specific program, for the purpose of making audits, examinations, excerpts, and transcriptions.

18.6.2.4. DBHDD, the Health and Human Services Inspector General, the US Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of Contractor that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts, and copies of such documents. This right also includes timely and reasonable access to a Contractor's personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not

limited to the required retention period, but will last as long as records are retained.

18.6.2.5. Following Contract termination, DBHDD will retain all its rights of access to relevant Contract records and data.

18.7 Reporting and PMs

18.7.1. The Contractor will comply with all PMs and reporting requirements as delineated in Appendices 18 and 26.

19 **IDD Case Management System**

19.1 The contractor will continue to operate IDD Connects (IDDC) as initiated in initial Business Requirements dated 8/19/2016 and subsequent requirements/specifications that were implemented.

19.2 Contractor will continue to monitor for and correct defects. Contractor may be required to complete updates and enhancements to IDDC to maintain or enhance functionality. As with other IT systems, the following will apply:

19.2.1 As part of this contract the Contractor will make the following modifications which will not result in a charge to DBHDD:

19.2.1.1 Add/Modify services, types of care, or combinations of care

19.2.1.2 Modify when CANS/ANSA is required

19.2.1.3 Modify authorization parameters

19.2.1.4 Add new values to existing data fields (online/batch). This includes existing lookup values, diagnosis codes, etc.

19.2.1.5 Modify system based on federal/state changes

19.2.1.6 Defect/Bug fixes/modification of system programming that does not meet requirement or functional specs

19.2.2 Requests for system functionality which fall outside the scope of the contract will be reimbursed:

19.2.2.1 Customize existing functionality to meet a Georgia specific need

19.2.2.2 Add a new file exchange (EDI process) not previously identified

19.2.2.3 Add new data elements to the PC/SCC/CBC/IDD screens or batch files

19.2.3 Due to the complexity of the IDDC system and our shared continual learnings we anticipate continuous improvement will be warranted. Cost allocation is not as clearly outlined in these instances and will need to be negotiated to determine if cost should be shared or allocated to one party. Examples include:

19.2.3.1 Modification of approved system functionality/code when:

19.2.3.2 project documentation or functional spec is unclear or inconsistent or there is a potential dispute

19.2.3.3 there is a system roadblock

19.2.3.4 Change in requirements after sign-off

19.2.3.5 Adding new functionality that retrofits current system functionality based on understanding of existing system

19.3 The termination activities of the contract (as outlined in Section 19.6 of the RFP), will now include the following:

19.3.1 The BHO and DBHDD program team members will jointly develop a project plan in support of completing the following activities:

19.3.2 <u>Decoupling from Connects</u>:

19.3.2.1 Detach the fully functioning and operational IDD Case Management System from Beacon's Connect Platform insuring it will "stand-up" (Beacon)[1].

19.3.2.2 Attach the fully functioning and operational IDD Case Management to other system that DBHDD determines (DBHDD)

19.3.3 Data transfer and migration from Connects:

19.3.3.1 All data, records, reports, documents, or other material that were obtained or prepared by Contractor in connection with performance under the contract shall become the property of DBHDD, and shall, upon request, be returned by Contractor to State, or at DBHDD's request to the successor Contractor at the Contractor's expense upon termination or expiration of this contract." Therefore, all data from the Connect System will be transferred in an agreed upon file format for DBHDD to consume in their target system. The updates to this file/s will continue until 6 months' post transition of the IDD Case Management System under the possession of DBHDD. (Beacon)

19.3.3.2 Import the data provided by Beacon into target systems (DBHDD).

19.3.4 Transfer of GA IDD Case Management System:

19.3.4.1 Install, setup and configure completed version of the system on the DBHDD owned and operated hardware (Beacon)

19.3.4.2 Install database and migrate contained IDD Case Management data to the DBHDD owned and operated hardware (Beacon)

19.3.4.3 Transfer and/or assign database and required software to run the IDD Case Management System right of use licenses to DBHDD as of cutover date (Beacon). Beyond the cutover date DBHDD will maintain the licenses with the respective vendors.

19.3.4.4 Deposit and deliver source code, technical and user documentation of the IDD Case Management system to a specific hardware identified by DBHDD (Beacon)

19.3.4.5 Cutover (12 months or earlier from contract termination date):

19.3.4.6 DBHDD to perform user test and provide signoff of the system operating as designed (DBHDD

19.3.5 Post cutover support/Warranty Period:

19.3.5.1 Continue to provide claims run out services on Connects for 6 months from cutover date (Beacon)

19.3.5.2 Provide incremental data from Connect on agreed upon frequency for a period of 6 months from cutover date (Beacon).

19.3.5.3 Continue to have the GA IDD systems running and available as of cutover date for fall back only in case it is needed.

19.4 DBHDD will extend the contract for termination activities referenced in point "7" above. BHO will

work with the required DBHDD team members, to deliver the items referenced in point “7” above, for a period of no more than 1.5 years and to not exceed a total cost of $2,500,000.00. Cost will be based on approved budget reflecting market cost for required labor and supporting activities.

19.5 Acceptance Sign Off will be required upon delivery of the items listed in section 7.1 above and demonstrated optimal system performance.

19.6 The Acceptance Sign Off date shall not extend past 1 year from the commencement of termination activities. The warranty period will begin the date of sign off and extend 6-months (System Performance Warranty period).

19.7 In the event of an early termination without cause, by either party, after the go-live, the terminating party agrees to pay additional termination/transition costs up to, but not to exceed $1,250,000.00 in the form of $212,400.00 for each year prior to the contract expiration of June 30, 2022.